

Improving **Children**'s Lives Transforming the **Future**

25 years of Child Rights in South Asia

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UNICEF's Regional Office for South Asia (ROSA) is dedicated to advancing the realization of the rights of all children in South Asia, especially the most marginalized and disadvantaged children. ROSA provides support and expertise to the eight UNICEF Country Offices and their partners in Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Sri Lanka and Pakistan.

This report was produced under the leadership of Karin Hulshof, Stephen Adkisson, Marc Vincent and Jean-Jacques Simon. It is the result of excellent collaboration with colleagues in the eight UNICEF Country Offices in South Asia, which we gratefully acknowledge. Ron Pouwels, Douglas Noble, Victor Aguayo, Leotes Helin and Henk Van Norden contributed individual chapters. Thoughtful inputs and suggestions were received from Eri Mathers Suzuki, Nuzhat Rafique, Rod Curtis, Yin Yin Aung and Shantanu Gupta. Itay Noy and Alessandra Heinemann coordinated the production of the content. Julie Harrod edited the report. Sarah Nam coordinated design and printing. Anoop Singh Gurung provided invaluable administrative support.

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Graphic design Giovanna Burinato
Photographs Thomas Nybo along with Adnan (p. 27, 31), Biswas (p. 46), Ferguson (p. 61), Haque (p. 63), Kiron (p. 36), Lavallee (p. 57), Mawa (p. 45), Romana (p. 64), Paul (p. 33), Zaidi (p. 42)
Colour separations and prints Althea Grafiche, Milan

An online version is available at www.generation25.org

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Foreword

On 20 November 1989, the world agreed that the human rights of children needed to be protected. The resulting Convention on the Rights of the Child, the most widely signed human rights treaty in history, is the world's promise to children everywhere. 2014 marks 25 years since the United Nations General Assembly adopted the Convention on the Rights of the Child.

To commemorate this historic promise, this publication will look at how the Convention has changed the lives of children over the last 25 years in the eight countries of South Asia, one of the fastest growing regions in the world. What have we achieved? What still needs to be done – and by whom? How do we fast track results for children with the Sustainable Development Goals?

Despite rapid economic growth in the region and consequent improvements in realizing the rights of children, massive disparities still exist which prevent millions of children from living in dignity, reaching their full potential and making choices about their futures. At UNICEF, we are united in our belief that everybody in South Asia has an obligation – and the potential – to do more to realize the rights of every single child in the region.

Not only is this is a moral imperative, but an economic necessity. Our children, the future leaders of this region, hold the key to well-being and prosperity for future generations. They depend on us. Please join us on this journey.

Karin Hulshof
Regional Director for UNICEF South Asia





Table of contents

10 | Introduction and policy ideas

13 | Sex ratio
Missing girls: gender-biased sex selection

19 | Neonatal mortality and skilled birth attendants
Too young to die

25 | Birth registration
Right from the start: ensuring the right to birth registration

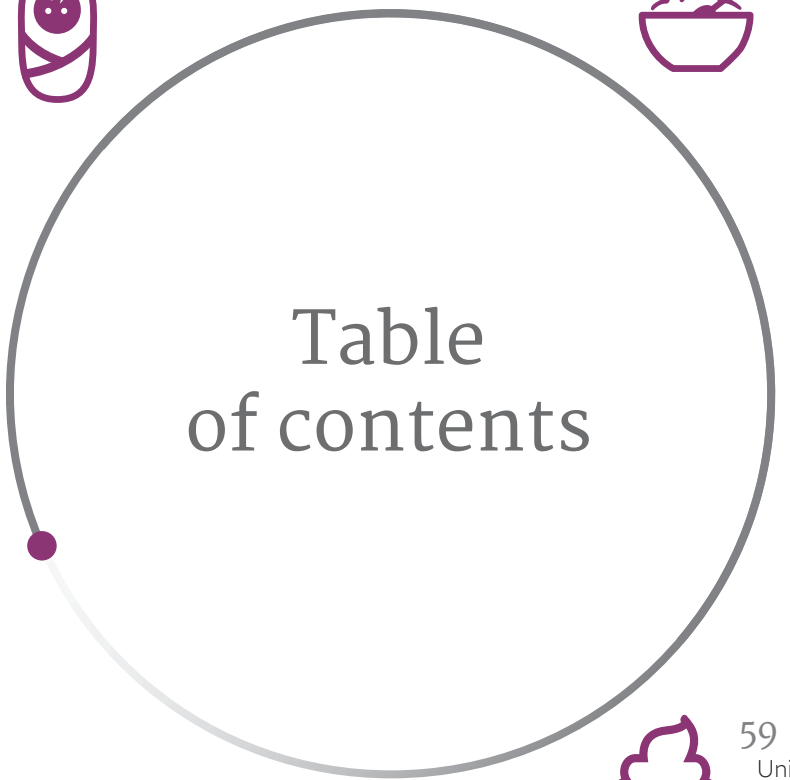
33 | Nutrition
The smart start for child growth and development

43 | Immunization
Ensuring protection

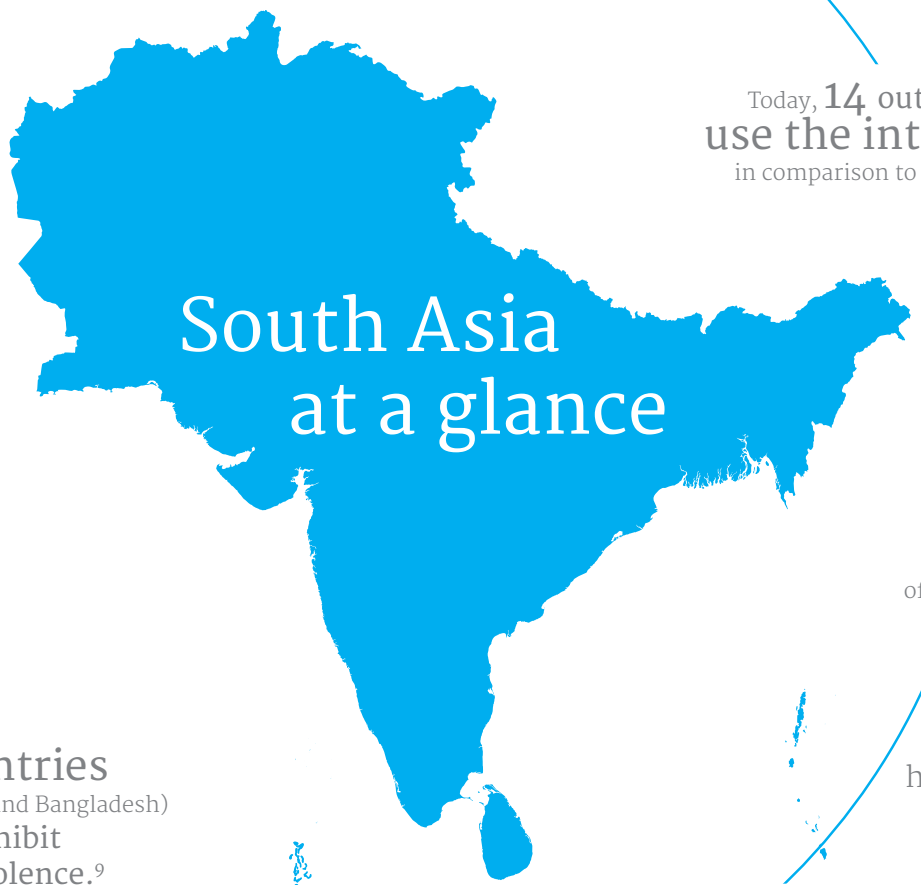
49 | Education
More children are in school but millions are still not learning

59 | Open defecation
Universal toilet use and hygienic behaviours

67 | Child marriage
Too young to wed




LAXMI PRAKASHAN



South Asia at a glance

Across South Asia,
1/3 of students
enrolled in the first grade
will leave school
before reaching
the last grade.[1]

Over 12%
of children in South Asia
aged 5-14 are engaged
in child labour.
In some parts
of the region,
the levels are much higher.[2]

More than
25 million adolescents
of lower secondary age
are out of school in South Asia
(a figure that is higher than the entire
population of Australia).[12]

Today, 14 out of every 100 people
use the internet in South Asia,
in comparison to less than one out of 100 in 2001.[3]

Across South Asia,
women make up
less than 5% of the police
and less than 10%
of judges.[11]

72% of South Asia's
population currently
have access to electricity.[4]

In Pakistan, a baby dies about
every three minutes.
In Nepal, three babies die
approximately every
two hours.[10]

South Asia has the second
highest number
of maternal deaths
worldwide (27%).[5]

In South Asia,
only 4 countries
(Sri Lanka, India, Nepal and Bangladesh)
have laws to prohibit
domestic violence.[9]

In India, more people
have a mobile phone
than a toilet.[6]

In South Asia,
an estimated 38% of children
under five are stunted
due to chronic nutrition deprivation.[8]

It is projected that in South Asia
more than one million
young people will enter
the labour force
every month in the next two decades.[7]

Introduction and policy ideas

Twenty-five years after the signing of the Convention on the Rights of the Child, where does South Asia stand?

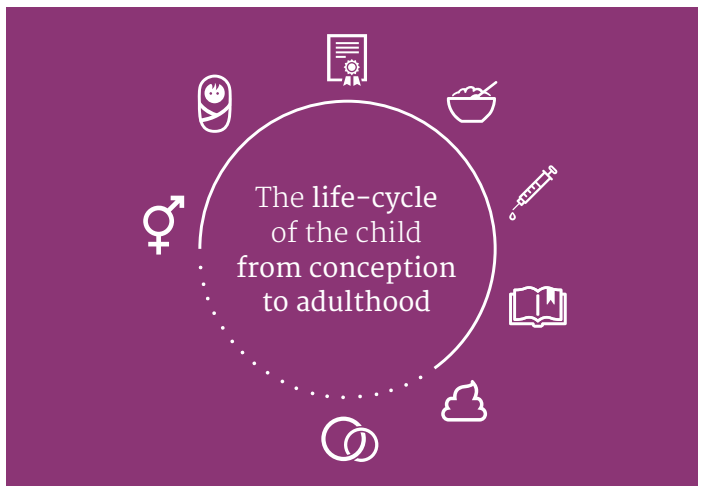
Over the past quarter-century, South Asia has made impressive progress towards realizing child rights. But there is more to be done – millions of children are still unable to live in dignity, reach their full potential or make choices about their future. This book presents data on key aspects of child well-being – child protection, health, nutrition, education, sanitation and gender – highlighting proven innovations and suggesting policies to realize the rights of all children in South Asia. It argues that fulfilling children's rights equitably is crucial to the region's future.

Twenty-five years ago, on 20 November 1989, the United Nations General Assembly adopted the Convention on the Rights of the Child (CRC), thereby recognizing children as having distinct rights rather than being the passive objects of care and protection. The CRC has inspired legislation, policy and institutional frameworks to respect, protect and fulfil child rights in all eight countries of South Asia – Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka.

All countries in the region have also ratified the Optional Protocols on protecting children from commercial sexual exploitation, and (with the exception of Pakistan) on protecting children in armed conflict. The Optional Protocol on a communications procedure has yet to be signed and ratified by countries in South Asia, with the exception of the Maldives which signed it in 2012.

Over the last twenty-five years, the region's children have seen real improvements in their lives, thanks to fruitful collaboration between governments, civil society and other interested parties. Yet poverty and disparities remain. Despite strong economic growth, South Asia's public expenditure on health, education and social protection are still far below that of other regions. Persistent gender discrimination remains a reality, undermining progress on all fronts.

Gender-based violence, abuse and exploitation continue to affect millions of children in South Asia. The problem tends to be especially severe for girls and boys who live in areas affected by conflict. Furthermore, children and adolescents are systematically denied the opportunity – by their families and the wider community – to speak for themselves on crucial issues: which career to pursue, when and whom to marry, whether and when to start a family.



The chapters of this book follow the life-cycle of the child from conception to marriage. They highlight areas where significant gaps still remain: gender, child protection, health, nutrition, education and sanitation. Each chapter points to proven new approaches and concludes with key policy ideas.

In commemorating the 25th anniversary of the CRC, this book calls on all of us to do more for the children and adolescents of South Asia. Most importantly, it calls on governments to transform the future by prioritizing child rights and investing in the well-being of all children.

Policy ideas: investing in child rights, transforming the future

Looking beyond the sector-specific policy ideas set out in the thematic chapters of this book, four overarching policy ideas can accelerate progress in realizing the rights of all children in South Asia.

1. MAKE EQUITY A PRIORITY

The development and well-being of all children should be a policy priority – this means extending services to the poorest and traditionally excluded groups.

- Governments should commit to explicit policy goals, based on national realities, for the well-being and development of all children and adolescents.
- Based on these policy goals, social-sector investment targeting the poorest and most marginalized children and adolescents should be stepped up.
- Clear lines of accountability and effective monitoring are critical. Where possible, civil society, and children and adolescents themselves should help monitor progress, including those from traditionally excluded groups.

2. TACKLE CHILD POVERTY

Investing in children is critical to breaking the inter-generational cycle of poverty and giving all children a fair start in life.

- Reducing child poverty should become an explicit policy priority with well-defined targets and accountability. Investing in children must be at the crux of every country's growth strategy.
- Greater investment in social protection, especially for the poorest and most vulnerable children, is critical to improving equity. Social protection, from early childhood through adolescence, not only reduces poverty but also has a knock-on effect on health, nutrition and education.
- Analysing the drivers of poverty in each country is critical to designing effective interventions. Poverty has many guises – it is seen in households with too little money and in patchy and unfair access to health care, education and protection services. It is also seen in the discrimination that marginalizes women, certain ethnic groups and low-caste individuals.

3. DELIVER INTEGRATED, CHILD-FRIENDLY SERVICES

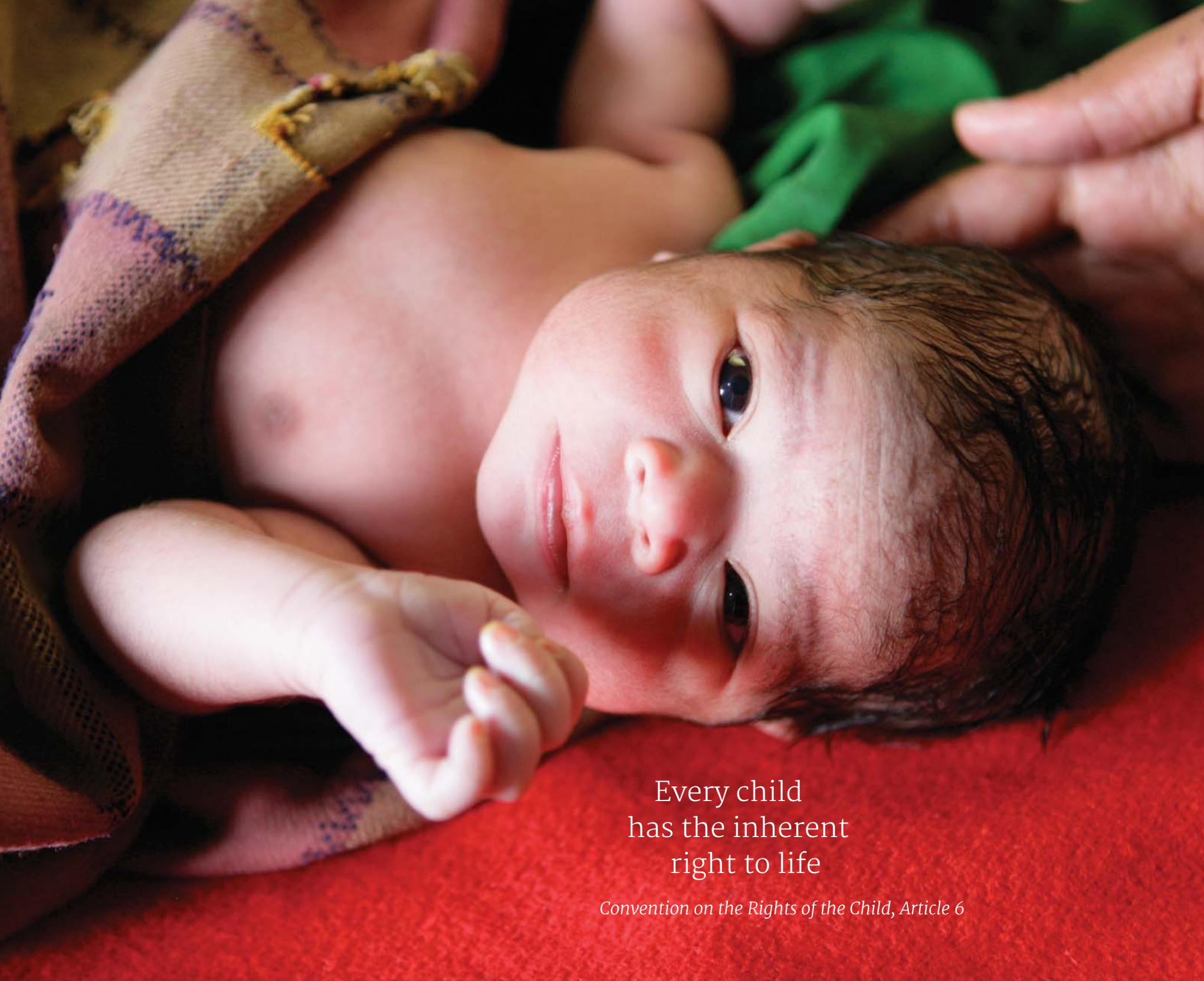
Good cross-sectoral collaboration can reinforce synergies between interventions and the delivery of services in a user-friendly manner.

- Important links connect the thematic areas discussed in this book. Ending open defecation, for example, is critical to tackling child undernutrition. Education is a powerful catalyst for better health outcomes and people's empowerment. Being healthy, immunized and properly fed makes children better able to learn. On the other hand, exposure to violence and abuse undermines a child's health and development. More experimentation and learning will allow us to exploit these linkages in programme design and implementation.
- Closer collaboration between sectors should aim to provide more user-friendly services, carefully tailored to meet the differing needs of children and adolescents. Children who are most vulnerable and marginalized often suffer multiple deprivations. Integrated, user-friendly services are critical to ensure access and uptake by traditionally excluded groups.

4. WORK TOWARDS GENDER EQUITY AND FULL PARTICIPATION

Equal opportunity for girls and boys, and participation in society are critical to transforming the lives of millions in South Asia.

- Gender discrimination is pervasive and persistent in South Asia. It underlies the high rates of violence and undernutrition suffered by women and girls; it is seen in the region's rates of child marriage (the highest in the world). Gender discrimination undermines progress for girls and boys, women and men, across all dimensions of human development. Tackling it is critical to the region's future.
- Being able to voice opinions to family members and, later, within wider society, is an essential part of growing up. Children learn step-by-step to make decisions, weigh pros and cons, and take responsibility for their actions. But children and adolescents are systematically denied the opportunity to speak out and influence decisions affecting their lives. Empowering children and particularly adolescents to become agents of change will unleash their potential.


Every child
has the inherent
right to life
Convention on the Rights of the Child, Article 6

Sex ratio

Missing girls: gender-biased sex selection

In some societies, parents prefer to have boy children: gender-biased sex selection (a form of prenatal discrimination) is the action taken to achieve this preference. Despite attempts to prevent sex selection, the practice continues (particularly in India) and it leads to an imbalance in the natural sex ratio (roughly 1:1 in the human population), with men outnumbering women.[13] Gender-biased sex selection favouring boys is a manifestation of deeply embedded social, economic, cultural and political factors that discriminate against women and girls. One potential risk in areas where men are in the majority is that girls from elsewhere may be trafficked for sex or to be forcibly married.

The sex ratio at birth is difficult to estimate in countries where children are often not registered at birth. The standard biological level of sex ratio at birth is 943-962 girls per 1,000 boys[14] although there are variations across regions, periods, and between ethnic groups. This imbalance disappears in adulthood, due to higher mortality rates among men than women.

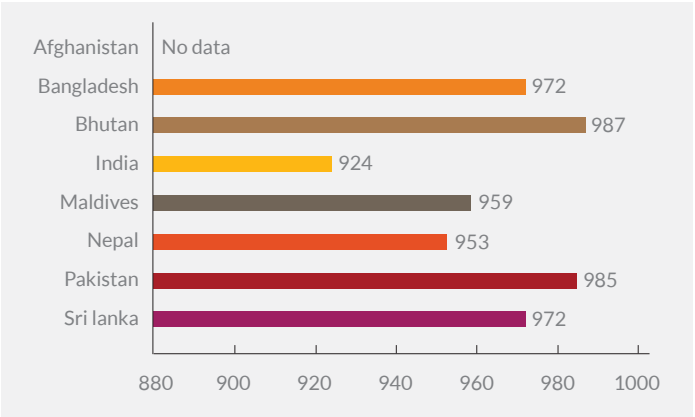
Confirming the presence of gender-biased sex selection requires both converging data (e.g. census-based sex ratios and birth samples) and additional information on existing technologies, reproductive behaviour and cultural preferences. Sex selection exists in societies where there is a strong cultural bias in favour of sons and is made easier where parents have access to prenatal diagnostic technology, including ultrasound scans, that allows them to find out the sex of their unborn child. Other factors which influence sex ratios are migration and armed conflicts, both of which take men away from the population temporarily or permanently.

Gender-biased sex selection is found in India, particularly in the west and northwest. Despite the existence of legislation that prohibits





CHILD SEX RATIO (NUMBER OF GIRLS PER 1,000 BOYS) AMONG CHILDREN AGED 0-4, South Asian Countries



Source: Census of Bangladesh 2011; Census of Bhutan 2005; Census of India 2011; Maldives' Department of National Planning data, 2006; Census of Nepal 2011; Pakistan Demographic and Health Survey 2012-2013; Census of Sri Lanka 2011

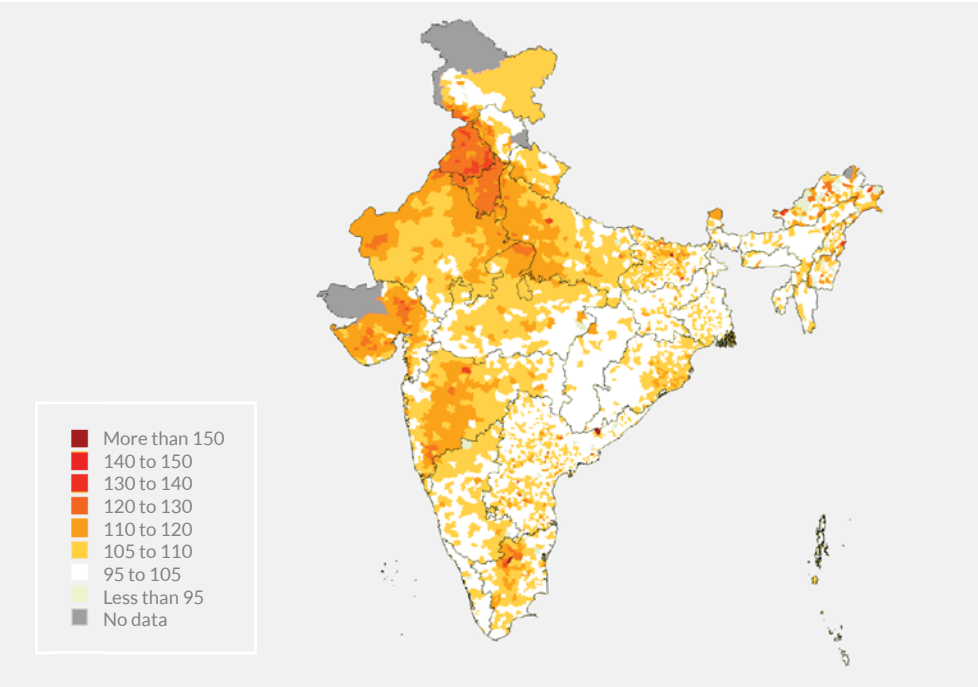
Note: Data for Sri Lanka is provisional, covering five percent of the population.

expectant parents from having tests conducted to determine the gender of unborn children, the situation is getting worse in India, although the rate of increase of the imbalance in the sex ratio may be slowing: India had close to seven million fewer girls than boys aged 0-6 in 2011.[15] The sex ratio imbalance increases with a mother's subsequent children: recent research concluded that selective abortions of girls, especially for pregnancies after a firstborn girl, have increased significantly in India.[16]

According to a recent United Nations Population Fund (UNFPA) publication, three factors contribute to gender-biased sex selection. The first is a preference for sons, stemming from patrilineal society where inheritance follows the male line and where women live with their husband's family after marriage. Such a society tends to place a lower value on women and girls, and expects that sons (rather than daughters) will support their parents in old age. The second factor is the increased availability of prenatal diagnostic technology, which enables parents to find out whether their unborn child is a girl (in which case they may choose to terminate the pregnancy). Finally, low fertility may increase the wish to choose the sex of a child.[17]

The map shows the wide variation in imbalances between sex ratios of children aged 0-6 in India. Such diversity in a single country requires further research into cultural traditions and the socio-economic factors that contribute to the phenomenon of gender-biased sex selection.[20] And the over-representation of men in certain populations has consequences, with some evidence suggesting that it may lead to trafficking of girls to be forcibly married and in some instances to be shared among brothers.[21]

CHILD SEX RATIO (NUMBER OF BOYS PER 100 GIRLS) AMONG CHILDREN AGED 0-6, Indian sub-district units, 2001



Source: UNFPA. 2012. "Sex Imbalances at Birth: Current trends, consequences and policy implications". www.unfpa.org/public/home/publications/pid/12405

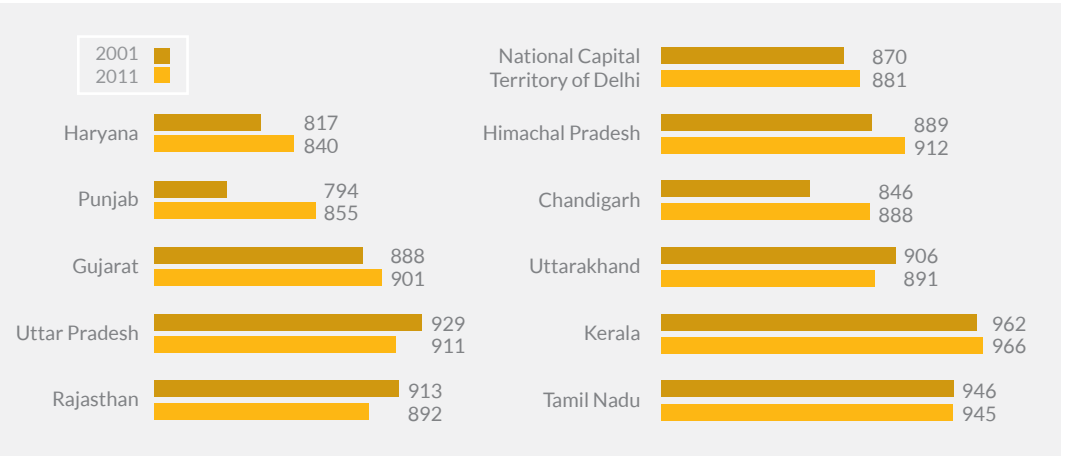
In India the sex ratio at birth is higher in wealthier households and near normal in the poorest: poorer households have higher fertility rates and less access to modern technology that is able to detect the baby's sex.[18] This tendency might lead – not only in India, but also in Nepal – to a bigger disparity between the numbers of boys and girls born as economic progress continues to lift people out of poverty.

The same publication provides a useful overview of the social, demographic and economic factors that affect sex selection in India. There is more sex selection in urban areas, and the role of religion appears to be significant (Hindus, Sikhs, Buddhists and Jains have comparatively higher sex ratio levels than Muslims or Christians). The sex selection ratio increases with educational level. Geographic location is the strongest source of sex ratio variations within the country.[19] There are complex dynamics between the different causal factors behind gender-biased sex-selection and more research is needed to determine the drivers for change.



The chart shows that the greatest disparities between the numbers of boy and girl children occur in the states of Haryana and Punjab. It also shows that although the disparities were still high in 2011, there was some improvement since 2001. The southern states of Kerala and Tamil Nadu have normal sex ratios.

CHILD SEX RATIO (NUMBER OF GIRLS PER 1,000 BOYS) AMONG CHILDREN AGED 0-4, Indian States, 2001-2011



Source: Census of India 2001 and 2011



Innovations and impact

SOUTH KOREA

Reducing imbalance in the sex ratio

The Republic of Korea is one of the few countries that has succeeded in reducing its highly imbalanced sex ratio at birth. A combination of factors contributed to this improvement (from 870 in 1994 to 935 in 2007): legislative measures to promote gender equality; rapid economic growth and fundamental changes in society such as more women in the workforce and parents having retirement savings; a media campaign; and effective regulation of sex-determination tests by a highly organized and controlled health system.

Ideas for moving ahead

South Asian countries should work to address sex imbalance through:

- Ensuring strong political commitment in promoting zero tolerance towards gender-biased sex selection.
- Collecting more evidence as a basis for advocacy and action: relevant information would include sub-national data and socio-economic variables.
- Improving the rate of birth registration (see thematic chapter on birth registration).
- Improving and implementing legal frameworks and policies that

promote and sustain gender equity and equality, including policies that address the root causes of son preference.

- Giving girls and women better access to education, health, nutrition, protection and information.
- Tackling the social norms that favour sons through advocacy, communication (including media campaigns), and community mobilization.
- Monitoring and evaluating interventions so that success (or failure) can be clearly demonstrated and learned from.
- Promoting the responsible use of technology that can determine the sex of the foetus, without compromising women's access to health services.[22]

Further reading

Office of the High Commissioner for Human Rights (OHCHR), UNFPA, UNICEF, UN Women and the World Health Organization (WHO): **Preventing gender-biased sex selection: An interagency statement**: whqlibdoc.who.int/publications/2011/9789241501460_eng.pdf

UNFPA: **Sex Imbalances at Birth: Current trends, consequences and policy implications**: www.unfpa.org/public/home/publications/pid/12405





States shall take measures
to diminish infant and child mortality,
and ensure appropriate
pre-natal and post-natal care for mothers

Convention on the Rights of the Child, Article 24

Neonatal mortality and skilled birth attendants

Too young to die

A newborn baby dying within the first month of life is a tragedy. With more than a million newborn deaths per year in South Asia, many mothers face the mental, physical and social trauma of losing their new baby.[23] Since almost 70 percent of neonatal mortality is avoidable, even without intensive care facilities,[24] improvements are certainly possible. As death rates in older children are falling faster than neonatal death rates, governments in South Asia need to focus on this area in order to reach Millennium Development Goal 4 (reduce child mortality by two thirds between 1990 and 2015).

There are more than a million neonatal deaths per year in South Asia.[25] Progress in reducing neonatal mortality (death in the first 28 days of life) has been slower than progress in reducing underfive and infant mortality: in South Asia as a whole, newborn deaths now account for more than half of all child mortality.[26] Tackling neonatal mortality is therefore increasingly important.

There are marked disparities in neonatal mortality between countries. Figures range from six deaths per 1,000 live births in Sri Lanka and the Maldives to 42 per 1,000 in Pakistan. In Pakistan a baby dies about every three minutes; in Nepal three babies die approximately every two hours.[27]

Although there are many causes of neonatal mortality, the main ones are premature birth, low birth weight, problems during delivery and infections. Globally, lower socioeconomic groups are more likely to have higher rates of neonatal mortality. Neonatal death is more common where health care for mothers is inadequate – mothers need high-quality health care throughout pregnancy, during labour and after giving birth.

Both UNICEF and the World Health Organization (WHO) advise that a skilled birth attendant should provide care during delivery, as this is an important way to reduce neonatal mortality. Yet there are vast



disparities in the access to and use of skilled birth attendants in South Asia – only 32 percent of births in Bangladesh occur in the presence of skilled health staff, whereas in Sri Lanka there is skilled health staff at almost every birth.[28] There is a lack of data on both numbers and quality of skilled birth attendants.

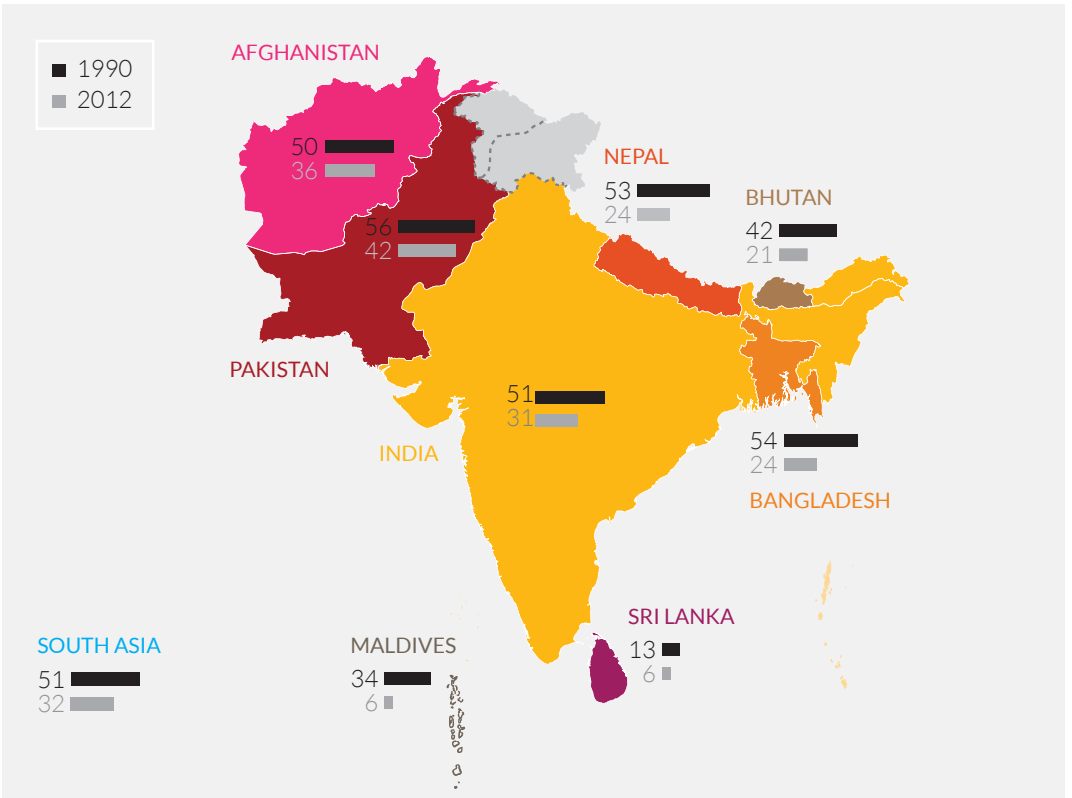
National averages can conceal wide differences associated with geography and social factors within a country. In Bangladesh, for instance, women in urban areas are better served than their rural peers: 54 percent of births in urban areas are attended by a medically trained provider compared to only 25 percent in rural areas. Affluence and good education also make a difference: about two thirds of the wealthiest women, and those who have completed secondary or higher education, have a medically trained provider at



All South Asian countries have seen declines in the newborn death rate, but for many countries progress has been slow

The decline in death rates within the first 28 days of life in the last two decades has been steady, but not as fast as reductions in the death rates of infants (children under the age of one) and underfive children.

NEONATAL MORTALITY RATES (DEATHS PER 1,000 LIVE BIRTHS), South Asia, 1990-2012



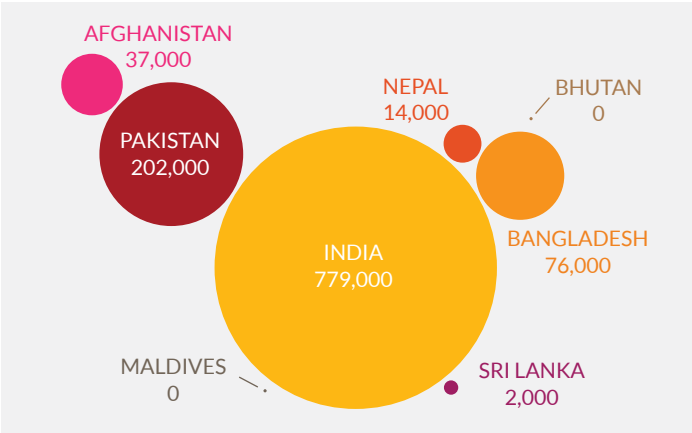
Source: UNICEF. n.d. UNICEF Data: Monitoring the Situation of Children and Women: Neonatal mortality. www.data.unicef.org/child-mortality/neonatal [accessed 4 July 2014]; UNICEF. 2013. "Levels & Trends in Child Mortality – Report 2013". www.childinfo.org/files/Child_Mortality_Report_2013.pdf

Note: The dotted line between Jammu and Kashmir represents approximately the Line of Control agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

birth.[29] In Nepal, 32 percent of rural births are attended by a skilled provider compared to 73 percent in urban areas.[30]

The reasons for higher death rates in very young babies are complex, but some of the solutions are well understood and urgently needed. They include having sufficient numbers and training of skilled birth attendants, high quality delivery facilities, and regular follow-up during pregnancy and after birth. There needs to be a special focus on the quality of care of newborn babies and on key interventions, for example the critical importance of breastfeeding.

NEONATAL DEATHS, South Asian countries, 2012

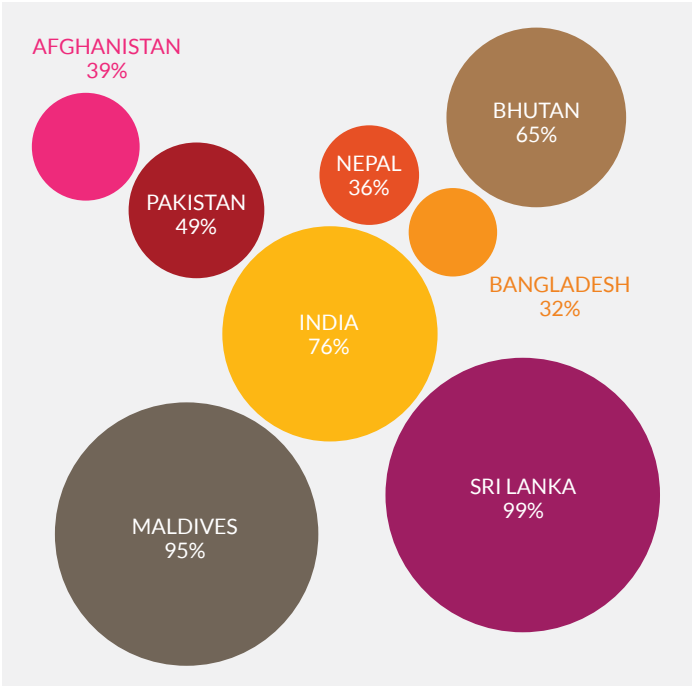


Source: UNICEF. 2013. "Levels & Trends in Child Mortality – Report 2013". www.childinfo.org/files/Child_Mortality_Report_2013.pdf

Note: Figures are rounded to the nearest thousand.

In South Asia there are vast disparities in the numbers of births attended by skilled birth attendants

BIRTHS ATTENDED BY SKILLED HEALTH STAFF (%), South Asian countries, 2007-2012



Source: World Bank. n.d. World Development Indicators: Births attended by skilled health staff. http://data.worldbank.org/indicator/SH.STA.BRTC.ZS [accessed 4 July 2014]

Note: Data for India is for skilled birth attendance, taken from the Coverage Evaluation Survey 2009.

Innovations and impact

BANGLADESH

Reviewing maternal and perinatal deaths to improve care

The Maternal and Perinatal Death Review (MPDR) is a mechanism for understanding the medical or social causes of death and using the information to establish effective preventative measures. UNICEF and the Government of Bangladesh have set up a review process with the Centre for Injury Prevention and Research. Bangladesh is the first country in South Asia to set up a community-based system (which includes verbal autopsies and social audits as well as facility-based examinations) to examine maternal deaths.

About 7,000 health and family planning field staff were trained to collect data to feed into the MPDR system, which focuses on context-specific socio-cultural factors and the barriers within the health system that contribute to maternal and neonatal mortality, and still-births. Involving communities in social audits raises local awareness and empowerment, while the flow of information from death reviews helps health workers design corrective strategies in collaboration with communities, non-governmental organizations (NGOs) and community-based organizations. Two barriers to access were a lack of skilled birth attendants in community clinics, and a

shortage of blood in remote district hospitals. Once identified, these barriers were overcome by deploying skilled personnel and setting up voluntary blood banks where needed. Regular review of MPDR information and its use for quality improvement has become a part of the health system that also feeds into government planning and decision-making.[31]

PAKISTAN

Chief Minister's Health Initiative for Attainment and Realization of Millennium Development Goals

The Punjab provincial health authorities, with financial and technical support from UNICEF and the United Nations Population Fund (UNFPA), have started providing 24-hour emergency obstetrics and newborn care services in flood-affected districts. Several new ideas have been developed, including performance-based incentives for staff on evening and night shifts. An e-monitoring system was devised with a central server at provincial level to receive SMS reports from health workers. Several innovative components were developed and implemented including financial flexibility, mechanisms of accountability and rewards, pay-for-performance, community involvement and awareness through a mobile phone text messaging service. As a result there has been an increase in antenatal care and institutional deliveries. Currently the Government of Punjab is scaling up the initiative across the province to improve maternal and newborn survival rates.[32]

INDIA, MADHYA PRADESH

Tracking babies treated in Special Newborn Care Units

In 2008, about 10 percent of premature or small-for-gestational-age infants discharged from Special Newborn Care Units (SNCUs) in part of the State of Madhya Pradesh died before the age of one. This was much worse than in other parts of the world, where post-





discharge mortality rates ranged from 2.3 to 3.8 percent.[33] To improve the survival rate of babies treated at SNCUs, the National Rural Health Mission and UNICEF set up a tracking system based on customized software and automated SMS messages. By tracking the babies after discharge, it is easier to ensure appropriate follow-up care, whether in the community or through the Units. The SMS system captures the records of all patients admitted to SNCUs and sends automated periodic alerts to community workers and family members. The system aims to ensure that babies receive six visits by trained community workers during the first month of life and that a total of five visits are made during the first year. The pilot scheme led to increased community follow-up care, and mortality rates in those successfully discharged from an SNCU dropped from 10 percent in 2008 to five percent in 2010, in one district.[34]

Ideas for moving ahead

Countries in South Asia should prioritize actions to improve newborn health, including:

- Supporting international initiatives of evidence-based best practice such as the Every Newborn Action Plan.
- Moving quickly to secure adequate numbers of skilled birth attendants, in the right place at the right time – including remote communities – who can deliver good quality services to mothers and newborn babies.
- Making sure that efforts to improve survival should not be over-medicalized – wider social determinants of health are also important, especially the wealth and education status of a child's mother.

Further reading

Every Newborn: An Action Plan to End Preventable Deaths: www.everynewborn.org/

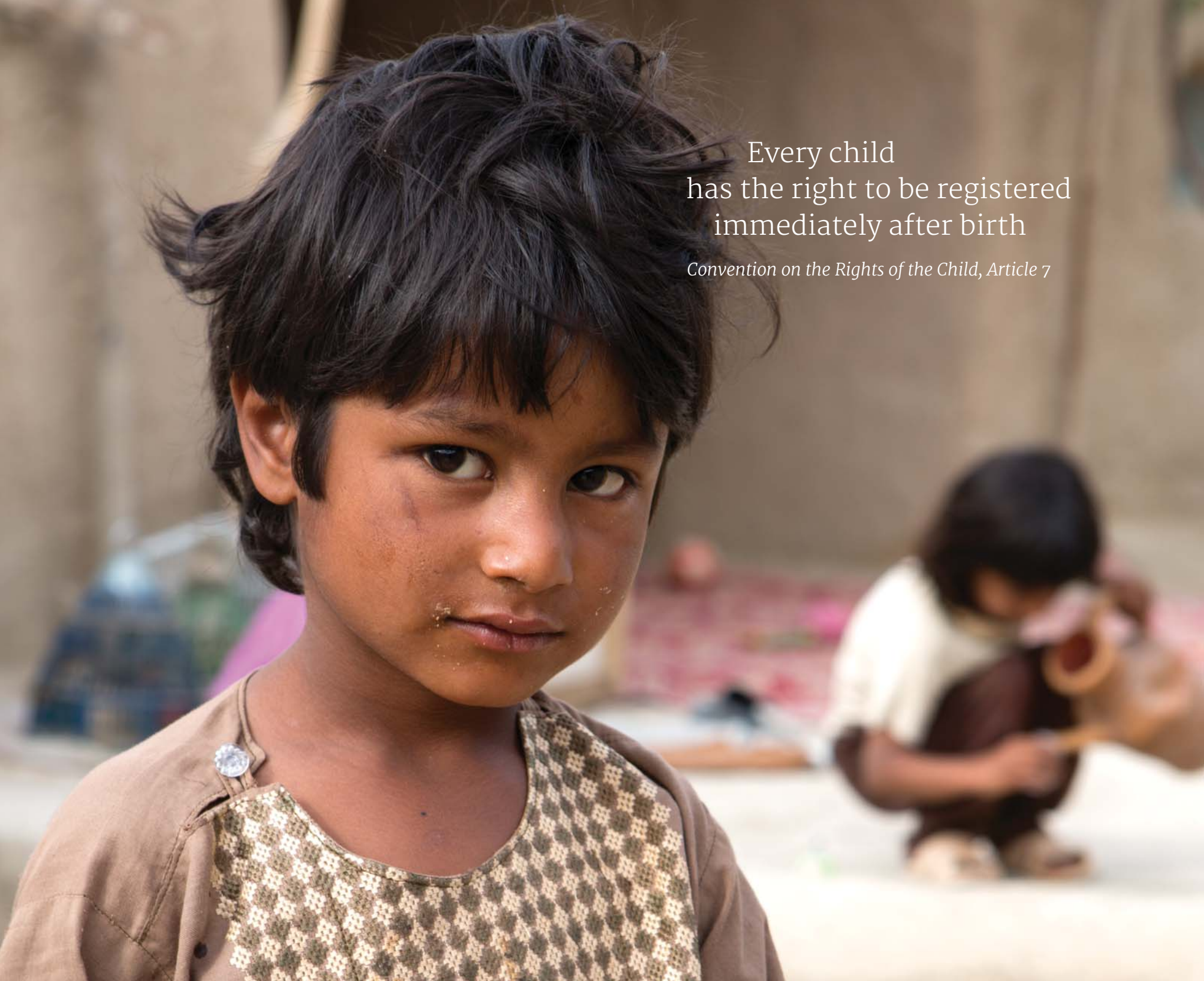
Lawn, Joy E. et al. for the Lancet Every Newborn Study Group: "**Progress, priorities, and potential beyond survival**": www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60496-7/fulltext

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Bhutta, Zulfiqar A. et al. for the Lancet Every Newborn Study Group: "**Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost?**": www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60792-3/fulltext



Every child
has the right to be registered
immediately after birth

Convention on the Rights of the Child, Article 7

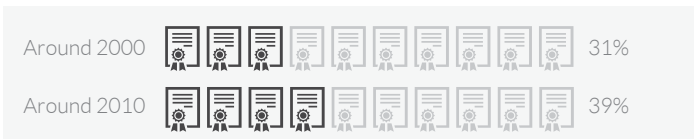
Birth registration

Right from the start: ensuring the right to birth registration

Birth registration – "the continuous, permanent and universal recording, within the civil registry, of the occurrence and characteristics of births in accordance with the legal requirements of a country"[35] – is the first formal recognition by the state of a child's existence. A lack of registration, which usually means that a child does not have a birth certificate, can result in the child being denied access to health services and education.

Being registered at birth also provides proof of a child's age. This should (although it does not always) provide protection against child marriage, child labour, under-age recruitment by armed forces or armed groups, and being treated as an adult when in conflict with the law. It can also help to convict those who have abused a child. At a later age, a birth certificate may be required to open a bank account, obtain a passport, exercise the right to vote or obtain social assistance. Birth registration also provides vital statistics for national planning, monitoring and budgeting.

CHILDREN UNDER THE AGE OF FIVE WHOSE BIRTHS WERE REGISTERED (%), South Asia, 2000-2010



Source: UNICEF. 2013. "Every Child's Birth Right: Inequities and trends in birth registration". www.unicef.org/publications/files/Birth_Registration_11_Dec_13.pdf

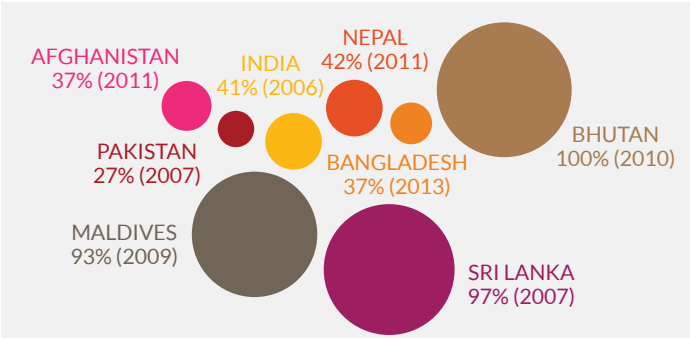
Note: This regional figure was calculated using data from National Family Health Survey 2005-2006 for India.

Birth registration levels in South Asia have increased since 2000, but progress has been slow. (The year 2000 is used as a baseline figure because birth registration was not systematically measured before that date.) Around 2010, 61 percent of children under the age of five in the region – or about 100 million children – did not have their births registered. The only countries recording significant improvements are Afghanistan, Bangladesh, India and the Maldives. While the national averages are still relatively low for Afghanistan and Bangladesh, the rate of improvement in these countries has been rapid.

Registering a child's birth (and marking the fact by issuing a birth certificate) gives legal recognition to the new individual. It is a vital step in realizing and protecting a child's rights, and ensuring his or



CHILDREN UNDER THE AGE OF FIVE WHOSE BIRTHS WERE REGISTERED (%), South Asian countries, 2006-2013



Source: Afghanistan Multiple Indicator Cluster Survey 2010-2011; Bangladesh Multiple Indicator Cluster Survey 2013; Bhutan Multiple Indicator Cluster Survey 2010; India National Family Health Survey 2005-2006; Maldives Demographic and Health Survey 2009; Nepal Demographic and Health Survey 2011; Pakistan Demographic and Health Survey 2012-2013; Sri Lanka Demographic and Health Survey 2006-2007

Note: Data for 1989 are not available for all countries in South Asia.
The level of birth registration in India has improved significantly, according to the 'Report on Vital Statistics of India based on the Civil Registration System' for 2011, Government of India. The reported level of birth registration of children born in 2011 was 84%.

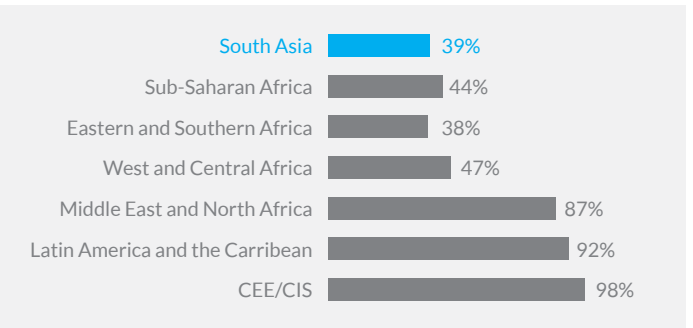
her inclusion within the social security system. Birth registration does not of itself guarantee protection, such as from child marriage, child labour or underage recruitment by armed forces or groups. Nor does it ensure access to education, health care and participation in civic life. But its absence can put these rights beyond the reach of those already on the margins of society, which exacerbates poverty, marginalization and exclusion. Despite progress in recent years, particularly in Afghanistan, Bangladesh, India and the Maldives, births of a considerable number of children in South Asia have not been registered.

Gender disparity is insignificant: in Bangladesh, Bhutan, India and Sri Lanka there is no difference at all between registration rates of boys and girls, and the difference in other countries is minimal. Other factors – place of residence (urban or rural), area within a country, relative wealth and the level of mother's education – are related to more significant disparities in birth registration rates.

In terms of household wealth, children from poor families in countries with low birth registration are less likely to be registered



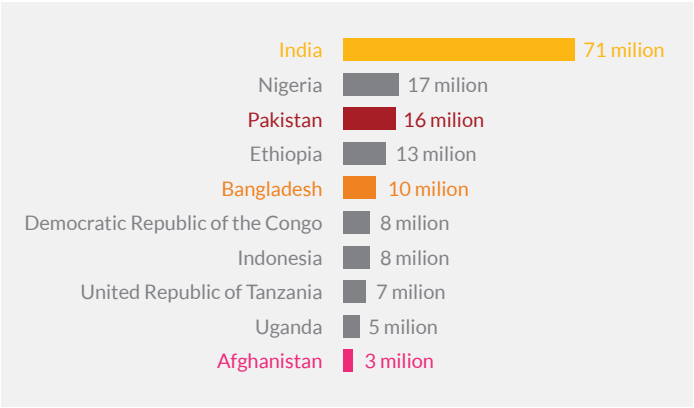
CHILDREN UNDER THE AGE OF FIVE WHOSE BIRTHS WERE REGISTERED (%), different regions, 2005-2012



Source: UNICEF. 2013. "Every Child's Birth Right: Inequities and trends in birth registration". www.unicef.org/publications/files/Birth_Registration_11_Dec_13.pdf

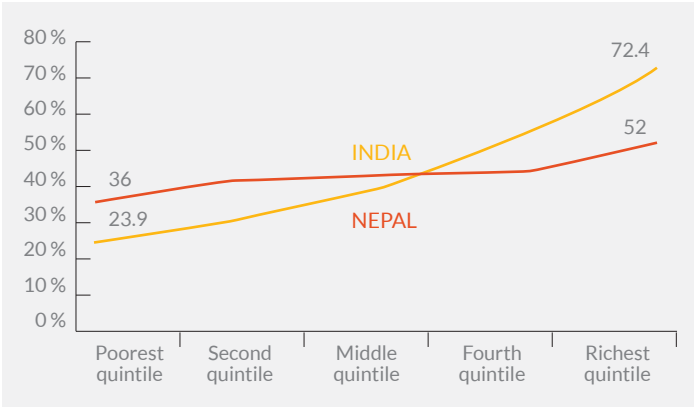
Note: CEE/CIS: Central and Eastern Europe and the Commonwealth of Independent States.

CHILDREN UNDER THE AGE OF FIVE WHOSE BIRTHS WERE NOT REGISTERED, countries with the largest numbers of unregistered children, 2000-2012



Source: UNICEF. 2013. "Every Child's Birth Right: Inequities and trends in birth registration". www.unicef.org/publications/files/Birth_Registration_11_Dec_13.pdf

CHILDREN UNDER THE AGE OF FIVE WHOSE BIRTHS WERE REGISTERED (%) BY WEALTH QUINTILE, India and Nepal, 2005-2011



Source: India National Family Health Survey 2005-2006; Nepal Demographic and Health Survey 2011



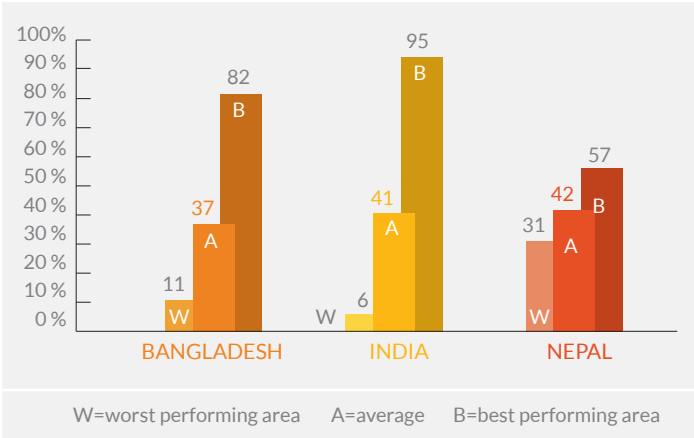
than children from wealthy families in those countries. India has the greatest disparity between the poorest and richest households, with children in the poorest households being three times less likely to be registered than children in the richest (24 percent versus 72 percent).[37] But in countries with high levels of birth registration (Bhutan, the Maldives and Sri Lanka) there is hardly any disparity in registration rates between poor and wealthy families.

In most countries in the region, the birth registration rate of children in rural areas is lower than in urban areas. But this difference is less pronounced than the disparity caused by relative wealth – except in Afghanistan (where only 33 percent of births in rural areas are registered, compared with 60 percent in towns) and India (35 percent in rural areas versus 59 percent in towns).

Geographical disparity within countries is a major concern, particularly in India, where the gap between best and worst



CHILDREN UNDER THE AGE OF FIVE WHOSE BIRTHS WERE REGISTERED (%) BY SUB-NATIONAL AREA, Bangladesh, India and Nepal, 2005-2013



Source: Bangladesh Multiple Indicator Cluster Survey 2012-2013; India National Family Health Survey 2005-2006; Nepal Demographic and Health Survey 2011

performing sub-national areas is 89 percentage points.[38] To put this in context, it is the same as the birth registration gap between Ethiopia and any Western European country.[39] Significant differences also exist between geographic areas in Afghanistan (41 percentage points), Pakistan (28 percentage points) and Nepal (26 percentage points).

Data disaggregated by mother's education are only available for Bangladesh and India, but the figures show great disparities, particularly in India, where there is a 50-percentage-point difference (25 percent versus 74 percent) between the birth registration rates of children born to uneducated mothers and children born to highly educated mothers. This is yet another demonstration of the importance for future generations of ensuring that girls have access to education.

Data on caste, ethnicity and religion are currently available only from India, so we cannot draw regional conclusions. Religion appears to play a role as certain groups such as Sikhs and Jains are more likely to be registered. Muslims have the lowest level of birth registration in India (39 percent) followed by Hindus (40 percent); the Jains have the highest (87 percent).

The low overall birth registration rate in South Asia and the major disparities discussed above are cause for concern in terms of access to services, child protection and exclusion in adulthood. Unregistered children are likely to be the very children who are already marginalized and unrecognized. Encouraging more parents to register their children's birth means tackling problems of access (distance to the registration facility) and cost (transport, loss of income while taking time off to register, paying for the certificate). Above all, parents need to be made aware of the importance of registration.

Innovations and impact

BANGLADESH

An inter-sectoral approach and a Birth Registration Information System

Bangladesh has increased the percentage of children under five whose births were registered from approximately 1.8 percent in 2000 to 9.8 percent in 2006 and 37 percent in 2013.[40] This success is due to a multi-sectoral intervention which included legal reform, awareness-raising and promotion through the education system and





via community health workers. Health systems are particularly well placed to inform and support the registration of births – community outreach workers may be present at home births, and immunization campaigns have a wide reach. UNICEF has been working to integrate birth registration into routine immunizations since 2007, such as by incorporating birth registration into immunization workers' training. Birth registration has also been included in several public health campaigns.

In parallel with these initiatives, the Bangladesh Birth Registration Information System (BRIS) was set up in 2009. With UNICEF support it has been rolled out to over 5,000 service points; its 100 millionth birth was registered in February 2014.[41]

AFGHANISTAN

Birth registration database

Afghanistan has seen a remarkable increase in birth registration rates, from six percent in 2003 to 37 percent in 2011.[42] An earlier birth registration system had fallen into disuse during the succession of conflicts, and in 2003 UNICEF started supporting the Civil Registration Department of the Ministry of Interior to revive the system. The Civil Registration Department is responsible for national ID registration, vital statistics (birth, death, marriage, divorce and refugees including internal displacement) and foreigners working in Afghanistan.

Given the challenges of birth registration in Afghanistan, the involvement of more than one government entity is crucial. An inter-ministerial task force was therefore set up by Presidential Decree to coordinate the relevant institutions. As well as the Ministry of Interior (whose official birth registrars are based in provincial and district offices), this involved the Ministry of Health (to register births in health facilities and immunization centres) and the Ministry of Religious Affairs (to register births through mosques), plus officially appointed community elders (to register births within their areas of responsibility).

The revived system was operated manually at first, but a web-based computer database, in two local languages and English, has been developed and is being used at provincial level. The database has

strict security, access is based on official hierarchy, and information is automatically backed up. Besides producing reports for government planning, the database also provides general information through the Ministry of Interior website. There is also a manager's dashboard, through which a provincial governor can examine the birth and death statistics of the province. Performance of registrars at various levels can also be monitored.

The database shows that Afghanistan is continuing to increase its birth registration rates. In 2012, about 268,100 children under one year of age were registered, while in 2013 the figure was 317,000 – an increase of about 15 percent.[43]

PAKISTAN

Birth registration by mobile phone

Pakistan has the lowest birth registration rate in the region, with 73 percent of its children under five not being registered. In March 2014, UNICEF Pakistan – working closely with its government counterparts such as the National Database and Registration Authority and Provincial Local Governments – teamed up with Telenor Pakistan to launch a pilot scheme to register births using SMS from mobile phones, which are already widely available throughout the country. Using mobile phones rather than having to go to an official birth registrar should make the process of registration much easier for parents. As well as the Mobile Birth Reporting System, the scheme includes a website and a central helpline.[44]



Ideas for moving ahead

Steps to increase birth registration include:

- Improving the birth registration system as an integral part of the civil registration system.
- Ensuring that birth registration is free of charge, and reducing the indirect costs of registration (such as travel) by bringing the service closer to families.
- Ensuring that all children born within the jurisdiction of a state have access to birth registration without discrimination.
- Raising awareness of the benefits of registering children and thereby creating demand.
- Combining birth registration services with other services – such as health and education – to reach children in rural and remote areas, and disadvantaged children.
- Using computerized birth registration systems where possible, to allow information to be permanently stored and easily retrieved.
- Registering births as soon as possible, to ensure accurate information is recorded, and providing the birth certificate promptly.

Further reading

Plan International: "**Birth Registration and Children's Rights: A Complex Story**": plan-international.org/files/global/publications/campaigns/birth-registration-research-full-report.pdf

UNICEF: "**A Passport to Protection: A Guide to Birth Registration Programming**": www.unicef.org/protection/files/UNICEF_Birth_Registration_Handbook.pdf

UNICEF: "**Every Child's Birth Right: Inequities and trends in birth registration**": www.unicef.org/publications/files/Birth_Registration_11_Dec_13.pdf

UNICEF: "**UNICEF Good Practices in Integrating Birth Registration into Health Systems (2000-2009)**": www.unicef.org/protection/Birth_Registration_Working_Paper(2).pdf



States shall take measures to ensure that parents are supported in the use of basic knowledge on child nutrition

Convention on the Rights of the Child, Article 24

Nutrition

The smart start for child growth and development

Nutrition is key to children's survival and development. Well-nourished children are healthier and cleverer than their undernourished peers, they grow and develop to their full potential, and they perform better in school and as adults. In South Asia, an estimated 38 percent of children under the age of five are stunted due to chronic nutrition deprivation.[45] Research shows that there is a critical 1,000-day window of opportunity – from conception to the age of two – to prevent child stunting and break the intergenerational cycle of undernutrition: once this window closes, for most children it closes for life.

In South Asia, stunting in children under the age of five is declining, but the estimated prevalence – 38 percent – is still too high, and comparable to that in sub-Saharan Africa.[46] Undernutrition in children can be seen in stunted growth – a stunted child is significantly less tall than would be expected for his or her age.[47] We use data on the prevalence of child stunting, between approximately 1990 and 2010, to assess progress and document trends in reducing child undernutrition in South Asia.

Recent global data indicate that 26 percent of children under five years of age (about 165 million) have stunted growth. The same sources indicate that stunting leads to about one million child deaths every year.[48] For the children who survive, stunting in early childhood causes lasting damage, including poor performance at school, reduced lean body mass, short adult stature, lower productivity, reduced earnings and – when accompanied by excessive weight gain later in childhood – a higher risk of chronic diseases.[49]

There is clear evidence that all children have similar growth and development potential in the first years of life. Global evidence also shows that a set of proven interventions from conception to the age of two – the 1,000-day window of opportunity mentioned above – can offer children the best start in life. Policies, programmes, research and advocacy therefore need to ensure that:

- Children are breastfed within the first hour of life and are fed only breast milk in the first six months of life to grow healthy and strong.
- Children are fed the right food – in quantity and quality – and





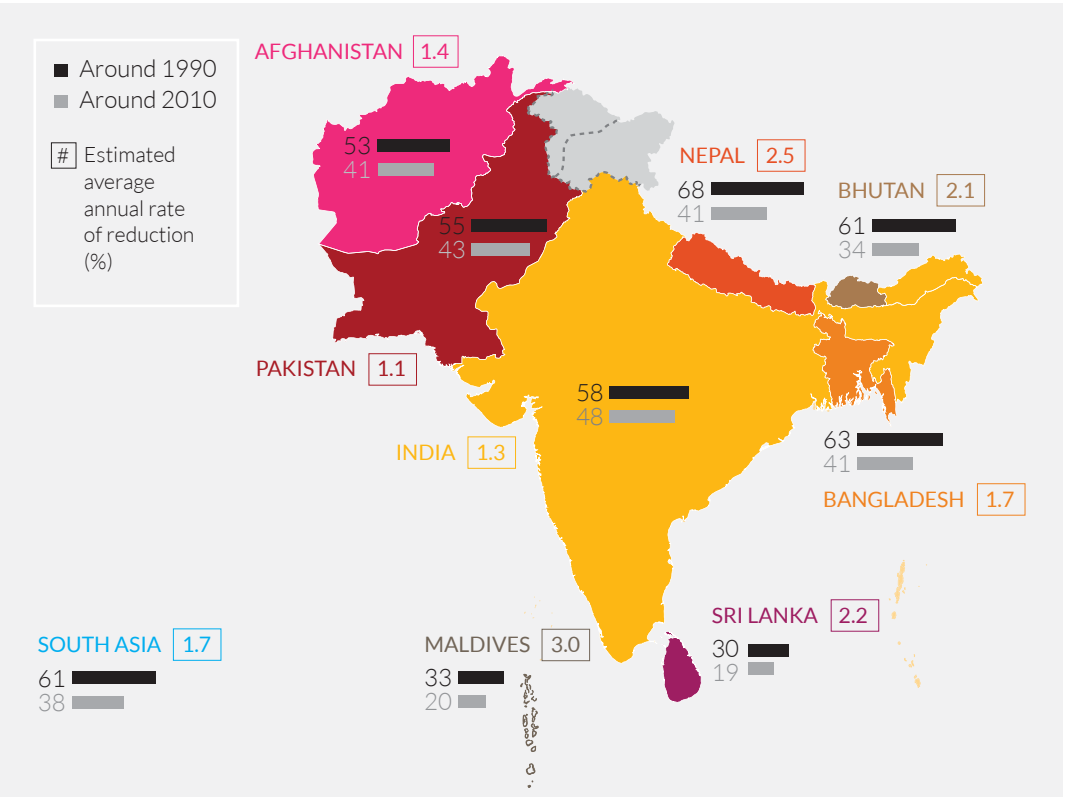
mother's milk after six months of age with safe and hygienic feeding practices to ensure optimal growth and development.

- Children are given essential vitamins and micronutrients, and full immunization, to strengthen their immune systems and protect them from nutritional deficiencies and disease.
- Children are given nutritious, life-protecting foods and care when they are sick or severely undernourished to ensure their survival and lasting recovery.
- Women benefit from good foods and care, including during adolescence, pregnancy and lactation, to secure their nutrition today and the nutrition of their children tomorrow.

The good news is that we know what works and, increasingly, we know how to make it work. Yet an estimated 38 percent of South

Despite improvements, progress in reducing child stunting is insufficient and unequal

PREVALENCE OF STUNTING AMONG CHILDREN UNDER FIVE (%), South Asia, 1990-2010



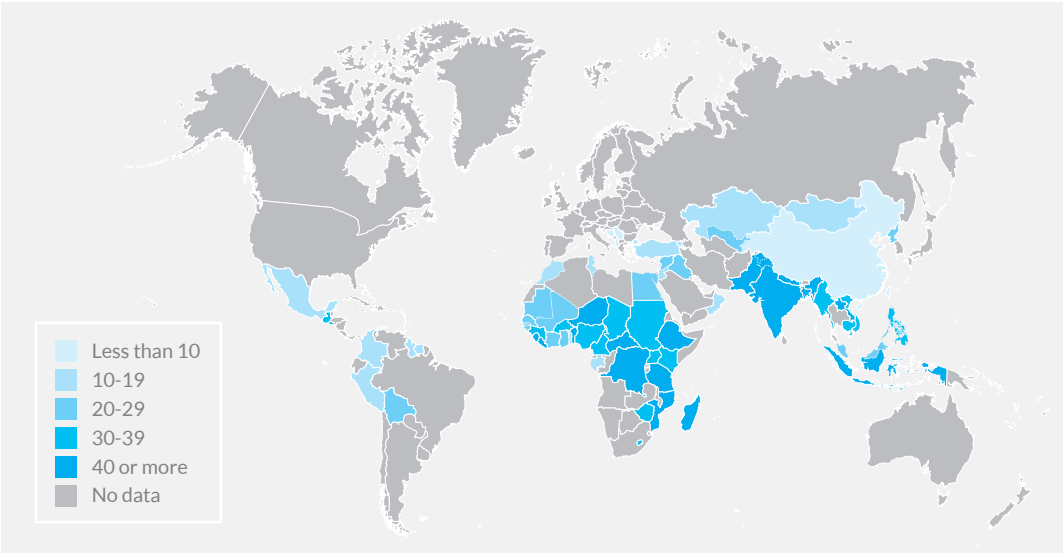
Source: UNICEF global database on child malnutrition; UNICEF/WHO/ World Bank. n.d. Global Health Observatory Data Repository: Nutrition: Joint child malnutrition estimates. apps.who.int/gho/data/view.wrapper.nutrition-1-1 [accessed 4 July 2014]

Note: The prevalence of child stunting in Afghanistan (41 percent, Afghanistan National Nutrition Survey 2013) was made public at the time of releasing this publication, but has not yet been incorporated into the global database.

The dotted line between Jammu and Kashmir represents approximately the Line of Control agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

South Asia is home to the largest number of stunted children worldwide

PREVALENCE OF STUNTING AMONG CHILDREN UNDER FIVE (%), different regions, 2012



Source: UNICEF global nutrition database, based on Multiple Indicator Cluster Surveys, Demographic and Health Surveys, and other nationally representative surveys [accessed 4 July 2014]

Note: The dotted line between Jammu and Kashmir represents approximately the Line of Control agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

Asia's underfives are stunted.[50] This high prevalence of stunting, combined with the region's large child population, explains why South Asia bears about 40 percent of the global burden of child stunting. Therefore, accelerating the reduction of stunting in South Asia is key to achieve the global target of reducing the number of stunted underfives by 40 percent by 2025.

The prevalence of stunting among underfives in South Asia has declined from about 61 percent in 1990 to about 38 percent in 2012, which represents a 38 percent decline over the last two decades. Every country has seen a reduction in the prevalence of stunting over the past twenty years. In Bangladesh, Bhutan, the Maldives, Nepal and Sri Lanka the prevalence of stunting declined by more than one third. The average annual rate of reduction in the prevalence of child stunting was 1.7 percent, ranging from about 1.1 percent in Pakistan to about three percent in the Maldives.

However, regional and national averages hide important disparities. Children from the poorest households, children who live in rural areas, children from families with a specific social identity (caste or ethnicity), and/or children born to particularly vulnerable women are more often stunted than those born in better circumstances.

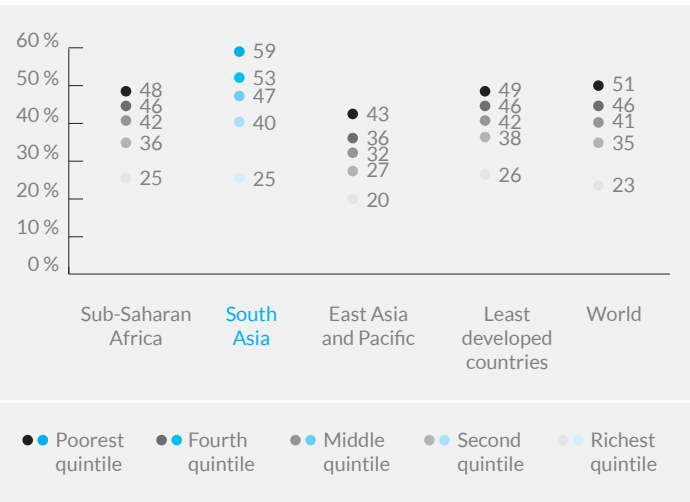


Throughout the world, child stunting is significantly more common in the poorest parts of society. This difference is particularly marked in South Asia: the prevalence of stunting in the poorest households (59 percent) is 2.4 times higher than the prevalence in the richest (25 percent). This compares unfavourably with sub-Saharan Africa, for instance, where the prevalence of stunting in the poorest households (48 percent) is 1.9 times higher than in the richest (25 percent).

Declines in the prevalence of child stunting have often been more pronounced in richer than in poorer households. For example between 1993 and 2006 in India – home to over 70 percent of the stunted children in South Asia – the prevalence of stunting declined by 42 percent in the richest group; the reduction in the poorest was only 14 percent.[51]

The prevalence of child stunting is significantly higher in the poorest wealth quintile in every region, but inequities are more pronounced in South Asia

PREVALENCE OF STUNTING AMONG CHILDREN UNDER FIVE (%) BY WEALTH QUINTILE, different regions, 2006-2012

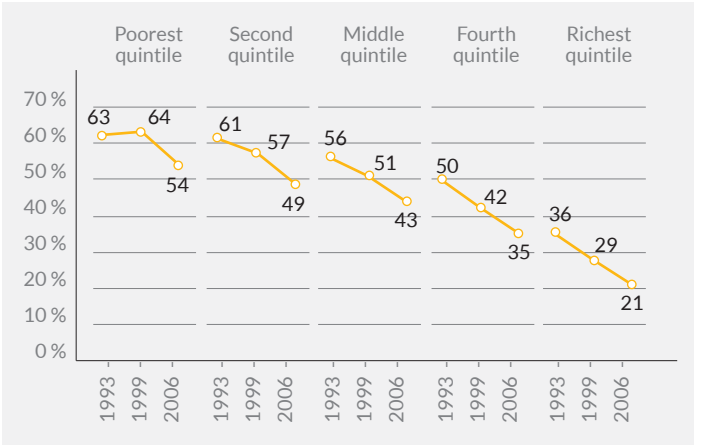


Source: Adapted from UNICEF. 2013. "Improving Child Malnutrition: The achievable imperative for global progress". www.unicef.org/publications/files/Nutrition_Report_final_lo_res_8_April.pdf

Note: Excludes China.

India: greater reduction in child stunting in richer households

PREVALENCE OF STUNTING AMONG CHILDREN UNDER FIVE (%) BY WEALTH QUINTILE, India, 1993-2006



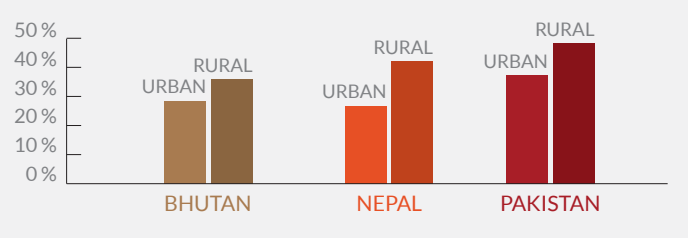
Source: UNICEF. 2010. "Progress for Children: Achieving the MDGs with Equity (No. 9)". www.unicef.org/publications/files/Progress_for_Children-No.9_EN_081710.pdf

Note: Prevalence estimates are calculated according to the National Centre for Health Statistics reference population, as there were insufficient data to calculate trend estimates by household wealth according to the World Health Organization (WHO) child growth standards.[52] Estimates are age-adjusted to represent children 0–59 months in each National Family Health Survey used.



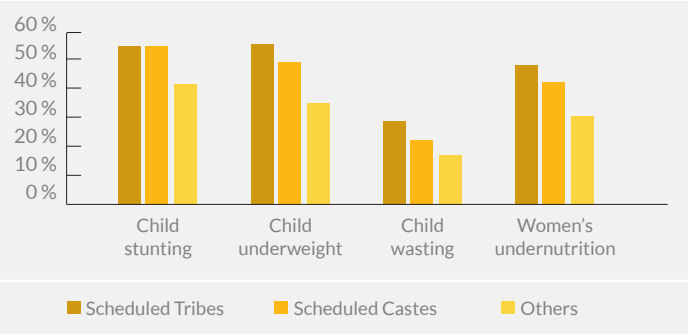
Children who live in rural areas are more often stunted. The prevalence of child stunting is higher among children living in rural areas than among those living in urban settings. For example, the prevalence of stunting among rural underfives in Nepal is 57 percent higher than among urban underfives. The corresponding values for Bhutan and Pakistan are 28 percent and 30 percent, respectively.

PREVALENCE OF STUNTING AMONG CHILDREN UNDER FIVE (%) IN URBAN AND RURAL AREAS, Bhutan, Nepal and Pakistan, 2010-2012



Source: Bhutan Multiple Indicator Survey 2010; Nepal Demographic and Health Survey 2011; Pakistan Demographic and Health Survey 2012

PREVALENCE OF STUNTING, UNDERWEIGHT, AND WASTING AMONG CHILDREN UNDER FIVE (%), AND PREVALENCE OF UNDERNUTRITION AMONG WOMEN AGED 15-49 (%), BY POPULATION GROUP, India, 2005-2006

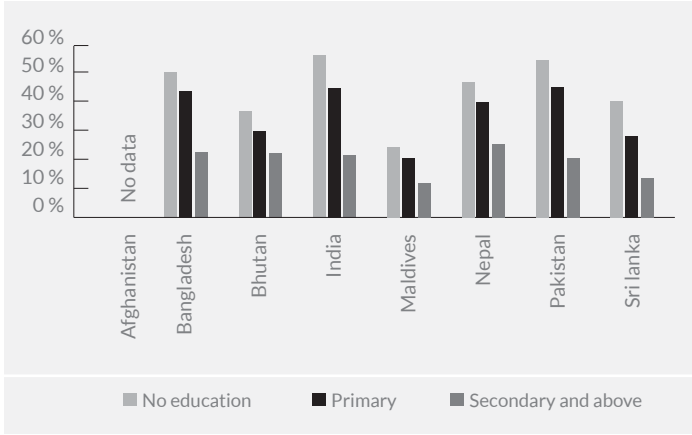


Source: India National Family Health Survey 2005-2006

Note: Child stunting, underweight, and wasting prevalence estimates are calculated according to the World Health Organization (WHO) child growth standards.[53] *Women's undernutrition is defined as the percentage of women 15-49 years old with a body mass index (BMI) < 18.5 kg/m2.*

Children born to women without formal education are those more often stunted

PREVALENCE OF STUNTING AMONG CHILDREN UNDER FIVE (%) BY MOTHER'S LEVEL OF FORMAL EDUCATION, South Asian countries, 2006-2012



Source: Bangladesh Demographic and Health Survey 2011; Bhutan Multiple Indicator Survey 2010; India National Family Health Survey 2006; Maldives Demographic and Health Survey 2009; Nepal Demographic and Health Survey 2011; Pakistan Demographic and Health Survey 2012; Sri Lanka Demographic and Health Survey 2011

Children from specific castes and ethnic groups are more often stunted. Caste and ethnicity underlie many of the disparities seen in the nutrition of children and women in South Asia. In India, for example, child stunting is more prevalent in Scheduled Castes (Dalit) and Scheduled Tribes (Adivasi) than in the rest of the population. Child underweight (low weight-for-age), child wasting (low weight-for-height), or women's undernutrition are also more prevalent in Scheduled Castes and Scheduled Tribes.

Children born to women without access to education are more often stunted. Lack of access to formal education for girls and women is closely linked to poor child nutrition in South Asia. In Bangladesh, India, Nepal and Sri Lanka the prevalence of stunting among children born to women without formal education is two and a half times higher (ranging from 41 to 57 percent) than among children born to women who have completed secondary education (14-26 percent).

Innovations and impact

INDIA

Improved governance for nutrition

Over 60 million Indian underfives - 48 percent of this age group - have stunted growth. Even in Maharashtra, India's second largest state, 46 percent of underfives were stunted in 2006. Maharashtra responded by launching the State Nutrition Mission, which began by improving the flagship programmes for child health, nutrition and development (the Integrated Child Development Services and the National Rural Health Mission), particularly in the most deprived tribal districts. Key vacancies, particularly community-based workers and their supervisors, were filled, and the motivation and skills of these frontline workers were boosted. In its second phase (2011 onwards), the Mission is focusing on the nutrition of children under two and their mothers, in line with global evidence indicating the need to optimise the 1,000-day window of opportunity to prevent stunting in children.



In 2012, the Government of Maharashtra commissioned the first-ever state-wide nutrition survey. It revealed that the prevalence of stunting among children under two had declined from 39 percent in 2006 to 23 percent in 2012, a decrease of 16 percentage points over six years. The decline was significantly higher among Adivasi children than among non-Adivasi children. Three factors seem key to the Maharashtra Nutrition Mission's success: (1) improving service delivery, by focusing on proven interventions for children under two and their mothers, and on the nutrition of adolescent girls; (2) delivering at scale with equity, by bringing services closer to the most vulnerable children, households and districts; and (3) coordinating and measuring nutrition results across sectors.

The Nutrition Mission has been a key policy instrument in the reduction of child stunting in Maharashtra. The main lesson learned is that a concerted effort to improve governance for nutrition has led to a measurable reduction in child stunting, particularly among the most vulnerable children: the youngest, the poorest and the socially-excluded.

NEPAL

Female Community Health Volunteers

In Nepal, the prevalence of stunting in underfives dropped from 57 percent in 2001 to 41 percent in 2011, largely as a result of the interventions delivered by Female Community Health Volunteers (FCHVs).

Nepal created the FCHV programme to increase the outreach of health and nutrition services. Currently, there are about 53,000 Female Community Health Volunteers delivering a range of essential services to children and women. The Volunteers promote and support mothers to use the best combination of breastfeeding and complementary feeding for children under two, a service that is integrated with the twice-yearly delivery of micronutrient powders to children aged 6-23 months. They supply deworming tablets to children aged 12-59 months, and provide care and referral services for children under five suffering from diarrhoea, acute respiratory infections, measles or severe acute malnutrition. Finally, they offer counselling and support to pregnant and breastfeeding women on nutrition, health and family planning.

Vitamin A deficiency is now believed to be largely under control; 80 percent of households use salt with adequate levels of iodine; the proportion of children under five with symptoms of pneumonia who are taken to a health facility for treatment has increased from 18 percent in 1996 to 50 percent in 2011; and the proportion of children with diarrhoea who are taken to a health provider for treatment has increased from 14 percent in 1996 to 38 percent in 2011.



In addition, in 2012, Nepal launched the Multi-Sectoral National Nutrition Plan under the leadership of the Prime Minister. The Plan aims to address the immediate, underlying and basic causes of maternal and child under-nutrition by focusing on the nutrition-specific and nutrition-sensitive interventions that prioritize a mother's pregnancy and her child's first two years of life.

SRI LANKA

Improved legislation, counselling and outreach

Sri Lanka has seen a significant improvement in the rate of exclusive breastfeeding in infants younger than six months, which increased from 53 percent in 2000 to 76 percent in 2007 due to policy and programme improvements.

One of the first countries to translate the International Code of Marketing of Breastmilk Substitutes into a national law, Sri Lanka has also achieved significant progress in maternity protection. In 1992, paid maternity leave in government jobs was extended from six weeks to 84 working days. Private sector employees covered under the Shop and Office Act are granted 84 days (including weekends and public holidays) of fully paid maternity leave for the first two children and 42 days for subsequent births.

Expanding the coverage and quality of the support provided to pregnant women and breastfeeding mothers has been central to Sri Lanka's progress on breastfeeding. Practically the entire health workforce in the country – paediatricians, obstetricians, primary care physicians and nurses – has benefitted from a 40-hour training course on lactation management. Mother-baby and lactation





management centres have been set up in all major hospitals to support breastfeeding mothers.

Finally, the contribution of over 7,000 government-trained public-health midwives cannot be overstated - they are an integral part of the team that delivers comprehensive maternal and child health care. During the first six weeks after delivery, each mother receives four home visits by her skilled birth attendant, who provides post-partum care and supports the mother to establish and maintain exclusive breastfeeding.

Sri Lanka's achievements in breastfeeding are the result of strong political commitment, a well-developed health system with professionals trained to support breastfeeding, a well-equipped and dedicated workforce of public-health midwives, and multiple strategies to raise awareness of the benefits of breastfeeding among mothers, families and communities.

Ideas for moving ahead

Four areas in nutrition need priority policy, programme and budgetary attention if South Asia is to meet the global target of reducing the number of stunted under-fives by 40 percent between 2010 and 2025:

- Improving the quality of food and feeding practices – including breastfeeding – for children in the first two years of life.
- Addressing the causes of prenatal stunting by improving women's nutrition and education, and eliminating adolescent pregnancy.
- Eliminating open defecation (see chapter on open defecation) and promoting hand-washing after defecation and before feeding children.
- Prioritizing the most vulnerable children and women – the youngest, the poorest, and the socially excluded – in policy-making, resource allocation, programme design, and in advocacy and research.

Further reading

UNICEF: **State of the World's Children Reports**: www.unicef.org/sowc/

UNICEF on nutrition: www.unicef.org/nutrition/index_4050.html

UNICEF: "**Improving Child Nutrition: The achievable imperative for global progress**": www.unicef.org/publications/files/Nutrition_Report_final_lo_res_8_April.pdf

World Health Organization (WHO) on nutrition: www.who.int/topics/nutrition/en/

United Nations World Food Programme (WFP): www.wfp.org

United Nations Food and Agriculture Organization (FAO): www.fao.org

Scaling Up Nutrition (SUN): scalingupnutrition.org

Renewed Efforts Against Child Hunger and Under-nutrition (REACH): www.reachpartnership.org

International Food Policy Research Institute: www.ifpri.org

Alive and Thrive: www.aliveandthrive.org

Helen Keller International (HKI): www.hki.org



States shall take measures
to ensure the child's right to health
through providing preventive health care

Convention on the Rights of the Child, Article 24

Immunization

Ensuring long-lasting protection

Immunization is one of the most cost-effective, life-saving health interventions for children, with results being real and long-lasting. If children are immunized against common childhood diseases, their chances of surviving to adulthood are significantly improved: roughly a third of deaths in children can be prevented by vaccination. For this reason, and because routine immunization is an important bridge to other health and nutrition interventions, prioritizing it is essential.[54]

Some countries in South Asia have made significant improvements in immunization since 1990 – particularly Bangladesh, Sri Lanka and Nepal – but coverage is still far too low in Afghanistan, India and Pakistan. There are also significant in-country disparities that are masked by country averages. For example, a survey in Shrawasti District in India's Uttar Pradesh State showed DTP3 (third diphtheria, tetanus, and pertussis vaccine) coverage was only 31 percent.[55] In Pakistan, over a quarter of districts have less than 80 percent coverage of DTP3; in Afghanistan, it is a third of districts.[56]

Some challenges to improving immunization rates are common to many countries. In particular, it can be difficult to generate demand for vaccination if communities and families are unaware of how vaccination can protect their children from disease. The process of buying vaccines, transporting them safely (which often requires the vaccine to be kept refrigerated) and delivering them to children – 'the supply chain' or 'cold chain logistics' – is a complex activity. Many countries lack the infrastructure and resources to ensure the integrity of this process, especially in remote areas. UNICEF provides specific help to countries both to increase awareness of the benefits of vaccination and to improve the supply chain.



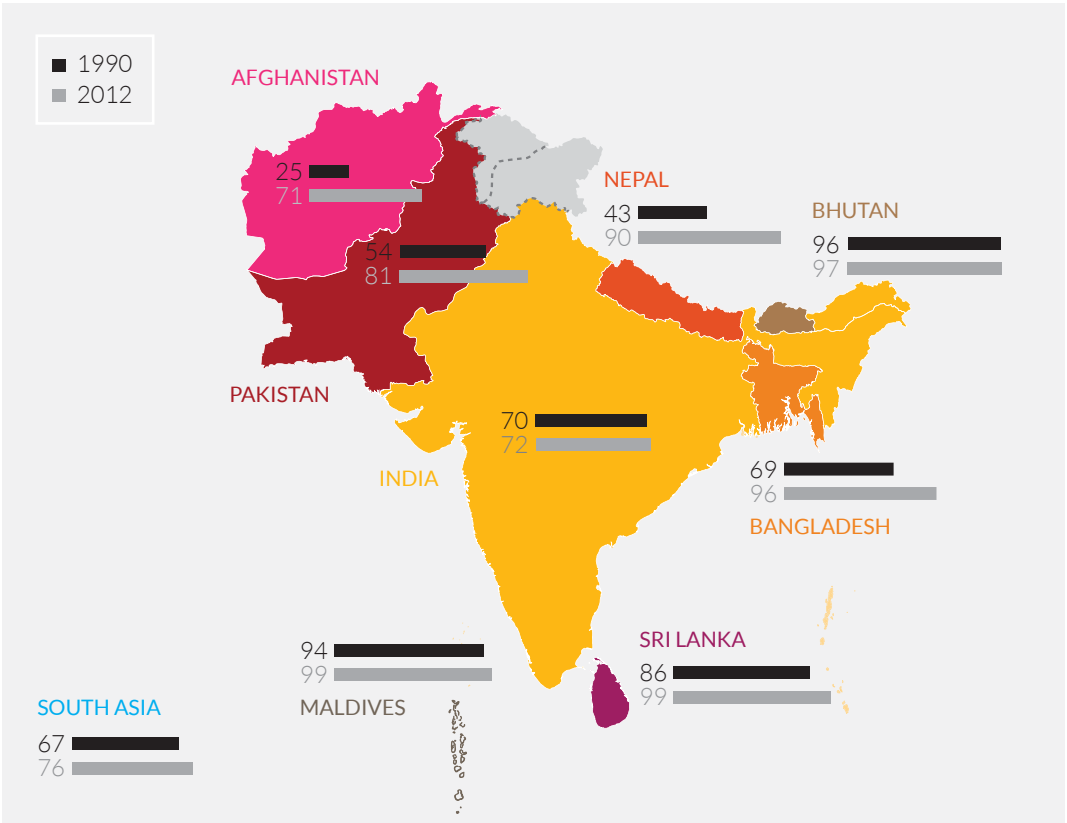
Despite the extraordinary success of vaccination programmes globally, about 23 million children under one year of age remain unimmunized, many of them in South Asia.[57] (In this publication, the word *unimmunized* refers to surviving infants who have not had a third dose of DTP in their first year of life). This situation needs to change, and the success with polio vaccination shows that the task of reaching the vast majority of children is not impossible.

The polio vaccine is of major global interest, and a vast global campaign is underway to eradicate polio completely. The use of the vaccine has seen the disease eradicated from 185 of 188 countries,



Immunization coverage in South Asian countries has improved over the last two decades, but more progress is needed, particularly in Afghanistan, India and Pakistan

IMMUNIZATION (DTP3) COVERAGE (%), South Asia, 1990-2012



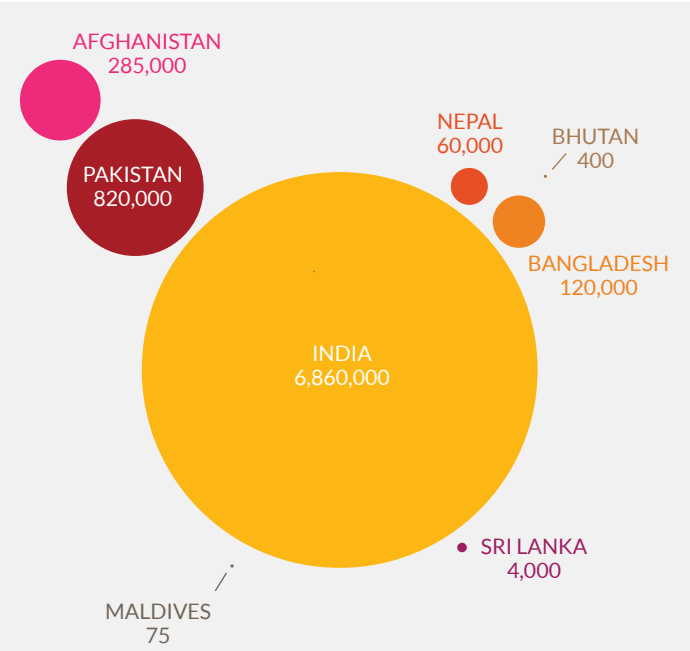
Source: UNICEF/WHO. 2014 "Immunization Summary. A statistical reference containing data through 2012 (the 2014 edition)". www.childinfo.org/files/immunization_summary_2012_en.pdf

Note: The percentages used for immunization coverage refer to DTP3 (third diphtheria, tetanus and pertussis vaccine). DTP3 coverage is a useful indicator of immunization programme performance and the strength of a country's health system. Immunization coverage can be estimated in different ways but reliable data is elusive. More accurate coverage rates can be determined by carrying out surveys.

The dotted line between Jammu and Kashmir represents approximately the Line of Control agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

with polio now restricted to decreasing pockets of transmission in often difficult-to-access areas. But, although six countries in South Asia are now certified polio-free, two of the world's three remaining polio-endemic countries – Pakistan and Afghanistan – are in this region. The remaining endemic country, Nigeria, appears closest to stopping transmission. As recently as 2009, India had 741 cases of polio and its achievement in stopping transmission in 2011 serves as an enduring reminder that polio can be stopped, even in the most challenging circumstances. The 2014 Polio-Free Certification of India, Nepal, Bangladesh, Sri Lanka, Bhutan and the Maldives is one of the most remarkable public health achievements in the region. However, unless Pakistan and Afghanistan can stop transmission in the remaining polio reservoirs, the threat of spread of polio transmission to polio-free countries in the region and around the world remains real.

NUMBER OF UNIMMUNIZED CHILDREN UNDER ONE YEAR OF AGE, South Asian countries, 2012



UNICEF/WHO. 2014. "Immunization Summary. A statistical reference containing data through 2012 (the 2014 edition)". www.childinfo.org/files/immunization_summary_2012_en.pdf

Innovations and Impact

BANGLADESH

Targeted immunization programmes

With UNICEF's support, the Government of Bangladesh identified 15 low-performing districts where a targeted strategy known as 'Reach Every Community' (making every effort to reach the unvaccinated children) was used to increase immunization coverage. This approach facilitated improving the national coverage of fully immunized children from 64 percent in 2005 to 80 percent in 2011.[58] In recognition of its outstanding performance in improving child immunization status, Bangladesh achieved the Gavi Vaccine Alliance Award in 2009 and 2012.[59]



PAKISTAN

Introducing a vaccine against pneumonia

More than 350,000 children in Pakistan die before reaching their fifth birthday – about 20 percent of them because of pneumonia. In 2012, Pakistan was first among South Asian countries to introduce the pneumococcal vaccine to prevent this deadly disease. UNICEF, Gavi the Vaccine Alliance, the World Health Organization (WHO) and other partners have all supported the Government of Pakistan in this initiative. The vaccine was introduced to Pakistan with the help of Gavi the Vaccine Alliance's Advance Market Commitment, under their strategic goal of shaping vaccine markets. This Commitment gives manufacturers an incentive to make large amounts of pneumococcal vaccine – developing countries therefore have the potential to receive the vaccine much earlier (perhaps up to a decade) than would have been the case without the incentive.[60]

INDIA

Strengthening polio immunization

By 2009, India had cornered the polio virus into just 107 stubborn blocks of transmission in western Uttar Pradesh and central Bihar. The virus persisted there for several reasons – high population density in Uttar Pradesh, a shifting flood plain in Bihar (which made it difficult to track and reach all children), poor sanitation, low routine immunization (DTP3) coverage and a high disease burden. To tackle the situation, the Government of India and its partners implemented the '107 Block Plan', concentrating resources on these blocks to ensure polio immunization campaigns were of the highest quality.

New interventions to address the factors underlying polio's continued transmission were introduced – UNICEF's Social Mobilization Network provided messaging on routine immunization, hand washing

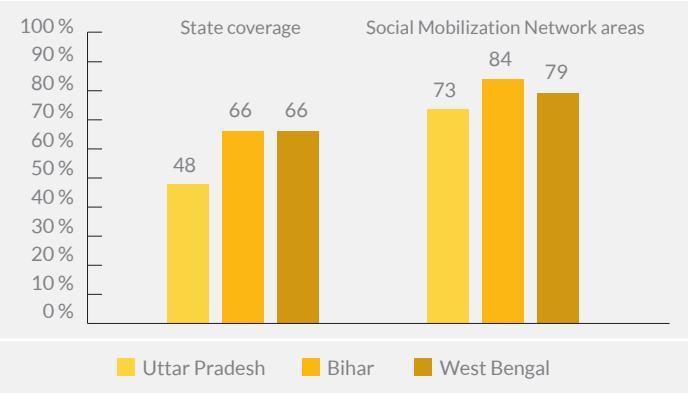


with soap, exclusive breastfeeding until six months of age, and how to prevent and treat diarrhoea. Clean drinking-water was brought to areas that had relied on polluted sources and almost 100,000 'dry' latrines were converted to flush toilets. To encourage mothers to bring their babies for immunization, nutritional supplements were given out with polio drops at immunization booths. Pregnant mothers were tracked and their newborn children recorded, so that social mobilizers could remind mothers to attend all five required routine immunization sessions in order to be protected against all vaccine-preventable childhood diseases. Potential dropouts were tracked by social mobilizers and in some areas were sent SMS messages stressing the need for full immunization coverage, and letting them know when and where the next session would be held. At the monthly polio meetings for mothers, the importance of routine immunization was a key message, and the social mobilizer used a flipbook to convey ideas about polio, provide information on what to do if a child has an adverse reaction to immunization and deal with any queries raised by the mothers.

Reaching 'every last child', including children in communities where social services were inadequate, was vital. Social mobilizers had to track migrant and nomadic groups, and build relationships with the owners and managers of businesses (such as brick kilns or construction sites) that hire seasonal labour. The mobilizers would then visit to make a 'due list' of children requiring routine immunization. A session for routine immunization – conducted by a government nurse on-site – was then arranged. UNICEF's Social Mobilization Network also enlisted the support of religious leaders for routine immunization, so that almost 5,000 mosques in Uttar Pradesh alone continue to make announcements about the importance of full routine immunization coverage in the lead-up to immunization sessions.

As a direct result of these interventions, Social Mobilization Network areas within these states now boast considerably higher routine immunization coverage than the state coverage overall (Uttar Pradesh: 73 percent compared with 48 percent in the whole state; Bihar 84 percent compared with 66 percent, and West Bengal 79 percent compared with 66 percent), despite being the most challenging and under-served blocks of the state.

CHILDREN FULLY IMMUNIZED (%), Uttar Pradesh, Bihar and West Bengal, 2009-2013



Source: Bihar Annual Health Survey 2013; Uttar Pradesh Annual Health Survey 2013; World Bank Coverage Evaluation Survey 2009; Community Mobilization Coordinator field book

Ideas for moving ahead

To improve immunization rates, and to achieve and sustain polio eradication, countries should consider:

- Targeting the most needy sub-national areas and tackling not just immunization and new vaccine introductions, but making wider efforts to improve nutrition, education, hygiene and sanitation, and to reduce poverty.
- Giving highest priority to immunizing children under five with polio vaccine in the remaining polio reservoirs, and supporting the introduction of the new Inactivated Polio Vaccine (IPV).
- Learning from Bangladesh to improve routine immunization coverage by using the 'Reach Every Community' approach.

Further reading

WHO Global Vaccine Action Plan 2011-2020: www.who.int/immunization/global_vaccine_action_plan/en/

Polio Eradication and Endgame Strategic Plan 2013-2018: www.polioeradication.org/resourcelibrary/strategyandwork.aspx

UNICEF on immunization: www.unicef.org/immunization/index_2819.html

WHO on immunization: www.who.int/topics/immunization/en/

Gavi, the Vaccine Alliance: www.gavialliance.org/



Every child
has the right to education
on the basis
of equal opportunity

Convention on the Rights of the Child, Article 28

Education

More children in school but millions are not learning, and millions more remain excluded

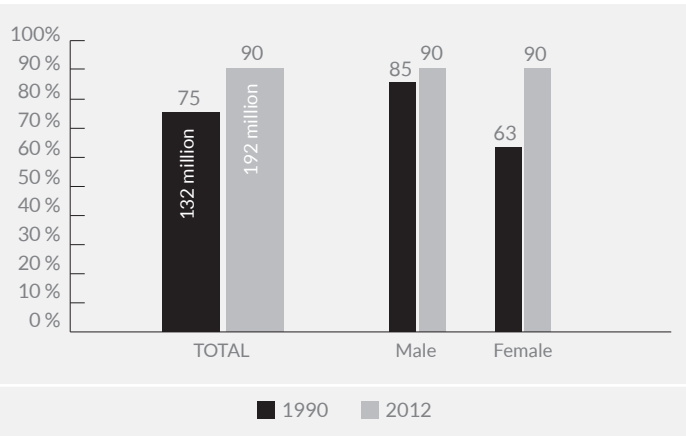
Education can unlock a better future. Educated people lead healthier lives; they can choose to be more responsible global citizens, reducing the incidence of conflict and war. Educated women are less likely to have been pushed into child marriage or push their own children into it; they are less likely to die in childbirth, and more likely to raise healthy children. Education is especially transformative for children who are poor, female and who live in remote areas.

Almost a quarter of a century has passed since 1990, when the international community pledged to provide education for all. Since then, the number of children attending school in South Asia has increased significantly – net enrolment in primary education has increased 15 percentage points, from 75 percent in 1990 to 90 percent in 2012. In 1990, there were 132 million children enrolled in the region's primary schools: by 2012 there were 192 million. The biggest progress is in the enrolment rate of girls, which has jumped 27 percentage points since 1990. However, gender equality in primary education remains elusive. Overall progress in enrolment has been stagnating: the net primary enrolment rate for South Asia has remained at 90 percent between 2009 and 2012.[61] Renewed efforts will be needed to reach the last and hardest-to-reach children.

Most countries in the region have seen remarkable progress in expanding access to education – the biggest increases being in Bhutan and Nepal. However, there has also been a slight decrease in enrolment rates over the last decade in Sri Lanka and the Maldives, where enrolment was near universal 10 years ago.

There are still too many children in the region who are not in school. Although most countries in South Asia have legislation making primary and/or basic education free and compulsory, an estimated 36.4 million children aged 5-13 are out of school. Of these, 9.9 million (aged 5-10) are not in either primary or secondary schools; the other 26.5 million (aged 11-13, 48 percent of whom are girls) should be in secondary education but are not in school at all.[62] In absolute numbers, the issue of out-of-school children in the region remains staggering – the only region in the world with more out-of-school children than South Asia is sub-Saharan Africa.[63]

NET ENROLMENT RATE (%), South Asia, 1990-2012



Source: UNESCO Institute for Statistics. n.d. Data Centre. www.uis.unesco.org/datacentre/pages/default.aspx [accessed 4 July 2014]

Note: Regional data is for South and West Asia as per the United Nations Educational, Scientific and Cultural Organization (UNESCO) regional grouping, which includes the eight South Asian countries (Afghanistan, Bangladesh, Bhutan, India, Maldives, Pakistan and Sri Lanka) and the Islamic Republic of Iran.

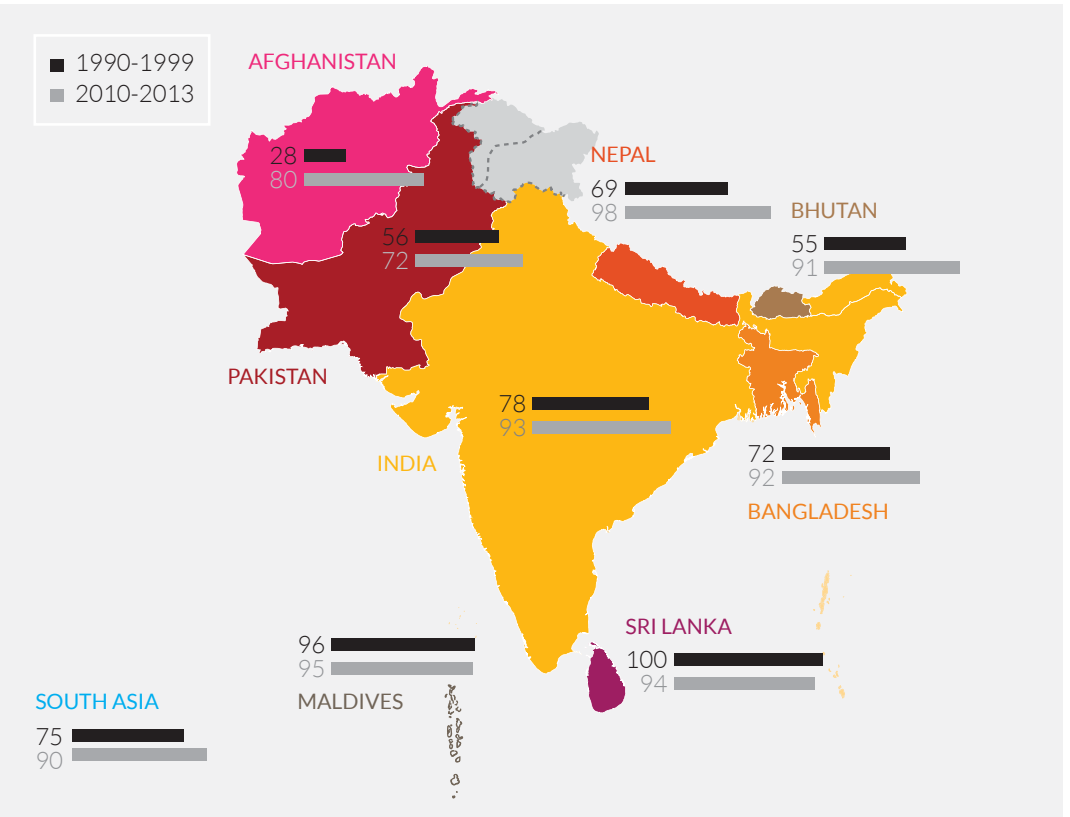


The Global Initiative on Out-of-School Children revealed that 27 million children (aged 5-13) are out of school in just four countries – Bangladesh, India, Pakistan and Sri Lanka.[64] Most of these children in the three largest countries live in rural areas and urban slums, and in the estate sector (tea plantations) of Sri Lanka.

In Pakistan, one in three children (or 33 percent) aged 5-9 are not in school.[65] In Bangladesh, the rate of exclusion from primary education[66] is 16 percent; the rate is 6 percent in India.[67] Exclusion is higher in specific groups, which suggests that poverty, caste, geographic location, gender and disabilities – as well as other factors – remain barriers to education. In India, girls aged 6-10 from Scheduled Castes are almost twice as likely not to attend school than

Most South Asian countries have seen remarkable progress in expanding access to education

NET ENROLMENT RATE IN PRIMARY EDUCATION (%), South Asia, 1990-1999 and 2010-2013



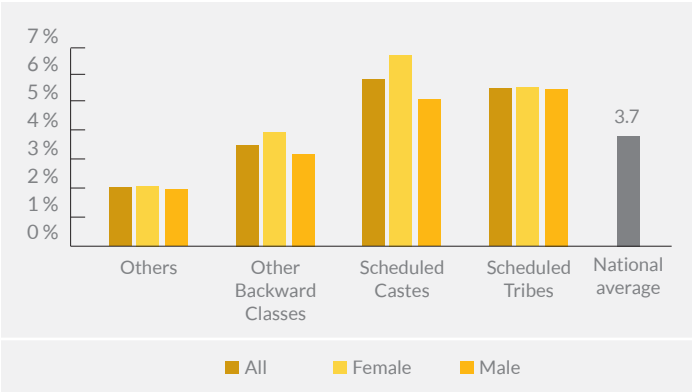
Source: UNESCO Institute for Statistics. n.d. Data Centre. www.uis.unesco.org/datacentre/pages/default.aspx [accessed 25 June 2014]

Note: Data for Afghanistan for 2010-2013 is gross rather than net enrolment rate, and is taken from the national Educational Management Information System. Data for the Maldives for 2010-2013 is adjusted net enrolment rate, taken from: UNESCO. 2014. "Education for All Global Monitoring Report 2013/4. Teaching and Learning: Achieving quality for all". unesdoc.unesco.org/images/0022/002256/225660e.pdf Regional data is for South and West Asia as per the United Nations Educational, Scientific and Cultural Organization (UNESCO) regional grouping, which includes the eight South Asian countries (Afghanistan, Bangladesh, Bhutan, India, Maldives, Pakistan and Sri Lanka) and the Islamic Republic of Iran.

The dotted line between Jammu and Kashmir represents approximately the Line of Control agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

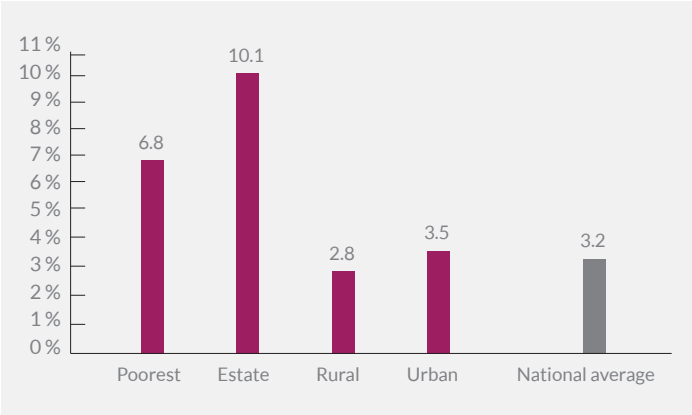
Exclusion in education in India: children from Scheduled Castes are more likely to be out of school, particularly girls

CHILDREN AGED 6-10 WHO ARE OUT OF SCHOOL (%) BY SEX AND SOCIAL GROUP, India, 2009



Source: UNICEF. 2014. "Global Initiative on Out-of-School Children: South Asia Regional Study". www.unicef.org/education/files/OOSCI_SouthAsia_14Feb_14_FINAL.pdf

CHILDREN OF LOWER SECONDARY SCHOOL AGE WHO ARE OUT OF SCHOOL (%) BY WEALTH LEVEL AND GEOGRAPHIC LOCATION, Sri Lanka, 2006-2007



Source: UNICEF. 2014. "Global Initiative on Out-of-School Children: South Asia Regional Study". www.unicef.org/education/files/OOSCI_SouthAsia_14Feb_14_FINAL.pdf

the average Indian child, and over three times more likely not to be attending school than an Indian girl who is not from a marginalized group. Children from Scheduled Castes and Scheduled Tribes are also more likely to be out of school.

Even in countries where there is near universal access to basic education, such as Sri Lanka, some groups are still excluded from schooling. Lower secondary school-age children from the tea plantation estates in Sri Lanka are more than three times more likely to be out of school than the average Sri Lankan child. The rate of exclusion for children from the poorest families is twice the national average.

Poverty is an important exclusionary factor in primary education, especially in Afghanistan and Pakistan. As the graph overleaf shows, of all the disparities measured using household survey data for five countries in the region, the most significant disparity is between the richest and poorest children in Pakistan, with a gap of 50 percentage points. Across South Asia as a whole, children from the richest families are 31 percent more likely to attend primary school than children from the poorest.[68]



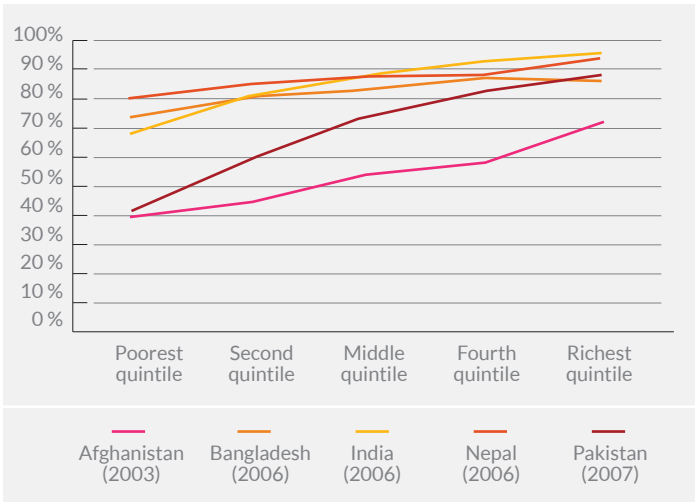


The most excluded children often face multiple barriers to education. For instance, girls with disabilities living in rural Nepal have the lowest access to education in that country. There are probably three major barriers to overcome here – the lack of rural schools that have suitable facilities for children with disabilities, gender bias in favour of boys, and misunderstandings about children with disabilities.

Emergencies caused by conflict and natural disasters (floods, cyclones and earthquakes) also take a toll on education. In Pakistan, armed conflict in Khyber Pakhtunkhwa in 2009 displaced an estimated three million people – some 600,000 children in three districts alone were reported to have missed at least a year of schooling in the three districts that saw the heaviest fighting.[69] And in Bangladesh, an estimated 1.5 million children missed out on education due to cyclones Sidr in 2007 and Aila in 2009, with damage to school infrastructure reckoned to reach USD 140 million.[70]

School attendance increases with wealth

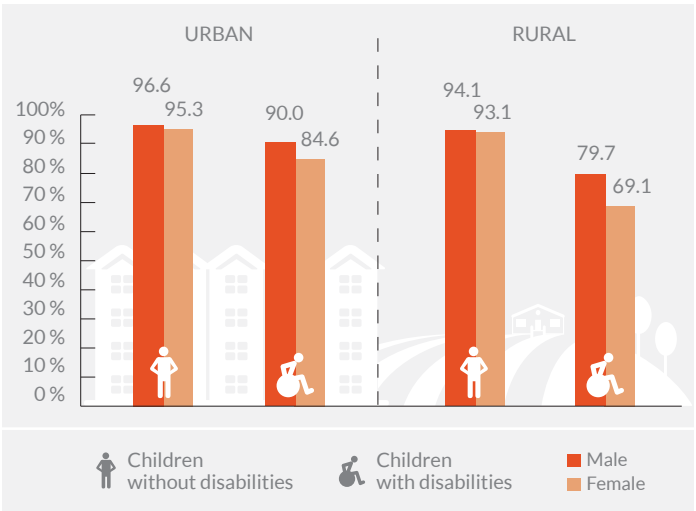
PRIMARY SCHOOL ATTENDANCE (%) BY WEALTH QUINTILE, South Asian countries, 2003-2007



Source: Multiple Indicator Cluster Surveys and Demographic and Health Surveys 2003-2007

Children with disabilities, particularly from rural areas, have the lowest access to education

CHILDREN WITH AND WITHOUT DISABILITIES WITH ACCESS TO EDUCATION (%) BY GEOGRAPHIC LOCATION, SEX, AND DISABILITY STATUS, Nepal, 2010-2011



Source: Nepal Living Standard Survey 2010-2011

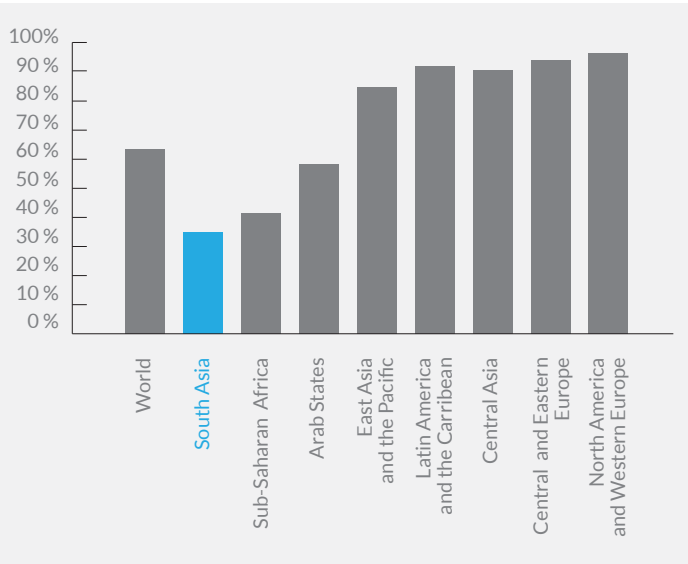
Note: Children with access to education are defined as those aged 5-14 who have ever attended school.

For children who manage to get to school, there are further challenges: completing the full eight to 10 years of basic education, and actually learning in the classroom. In South Asia, only 64 percent of children who enrol in Grade 1 reach the last grade of primary education (data for 2010); this figure has hardly changed since 1999, when 62 percent reached the last grade.[71] Perhaps more worrying is the fact that only a third of children in South Asia who have had at least four years of primary education meet minimum learning standards,[72] a lower proportion than in any other region.

This learning crisis – where attending school produces no tangible results – effectively robs children of their most receptive years. It also represents a huge loss of investment. Some groups of children are affected more than others, again reflecting the disparities in society, and there are geographic differences too. In India, for example, the 2013 Annual Status of Education Report shows that, nationally, only 47 percent of Grade 5 (Standard V) students can read Grade 2 (Standard II) text. Children in private schools have a higher reading score (63 percent) than those in government schools (41 percent).[73]

South Asia learning crisis: only one in three children with four years of schooling can read

CHILDREN WHO SPENT AT LEAST FOUR YEARS IN SCHOOL AND LEARNED THE BASICS (%), different regions, 2004-2012



Source: UNESCO. 2014. "Education for All Global Monitoring Report 2013/4. Teaching and Learning: Achieving quality for all". unesdoc.unesco.org/images/0022/002256/225660e.pdf

Note: Regional data is for South and West Asia as per the United Nations Educational, Scientific and Cultural Organization (UNESCO) regional grouping, which includes the eight South Asian countries (Afghanistan, Bangladesh, Bhutan, India, Maldives, Pakistan and Sri Lanka) and the Islamic Republic of Iran.



Reading scores vary between states too – Puducherry in South India and Madhya Pradesh in central India have the lowest; Kerala and Himachal Pradesh have the highest.[74]

In Pakistan, 51 percent of children in the fifth year of primary education (Grade 5) cannot read Grade 2-level text in their local language, while 57 percent of Grade 5 children cannot do two-digit division. There are gender disparities too. In rural Pakistan, only 38 percent of girls can do simple arithmetic compared with 45 percent of boys. The gender difference is smaller when it comes to reading, but again fewer girls (43 percent) than boys (48 percent) can read.[75] When broken down by income level, the gender gap almost disappears in children from the richest families. Thus girls from the poorest families in Pakistan are most disadvantaged when it comes to learning achievements: only 15 percent of girls from the poorest families can read basic Urdu (the figure is 21 percent for boys from the poorest families) compared to 42 percent of girls from the richest families.

Disparities in learning achievement: girls from the poorest families lag behind

CHILDREN WHO CAN READ A STORY IN URDU (%) BY SEX AND WEALTH LEVEL, Pakistan, 2013



Source: South Asian Forum for Education Development. 2013. "Annual Status of Education Report – Pakistan 2013". aserpakistan.org/document/aser/2013/reports/national/ASER_National_Report_2013.pdf

Innovations and impact

BANGLADESH

Alternative opportunities for learning

Bangladesh has a long history of non-formal education, largely delivered by non-governmental organizations (NGOs) such as BRAC (formerly Bangladesh Rural Advancement Committee), Friends In Village Development Bangladesh (FIVDB), Gonoshahajjo Sangstha (GSS) and Dhaka Ahsania Mission. Until the 1980s, this type of education catered mainly to illiterate young people and adults, but the concept has been introduced to a younger age-group (children aged 8-14) in response to the huge numbers of out-of-school children. Non-formal primary education now complements formal education, giving children the chance to learn basic literacy and numeracy, and to enrol or re-enrol at school. Some NGOs link learners with vocational



and livelihood education. About six million children have benefited from non-formal primary education in the last three decades.

The government has memoranda of understanding with many providers of non-formal primary education but does not manage their programmes directly. The Ministry does, however, have several non-formal programmes of its own, such as the Reaching Out-of-School Children project, which uses the same instructional materials as the formal system. Another government project – Basic Education for Hard-to-Reach Urban Working Children – is supported by UNICEF. It has its own curriculum and emphasizes functional literacy and life skills. In 2013, the government approved the guidelines on Second Chance Education, which institutionalized government support to non-formal education programmes.[76]

INDIA

Reaching out-of-school girls from the most disadvantaged groups

India has set up a specialized type of school – for girls only, with boarding facilities for some of the pupils – to attract out-of-school girls in rural areas. Called Kasturba Gandhi Balika Vidyalayas (KGBVs),



these single-sex lower secondary schools make education more attractive to girls from groups such as Scheduled Castes, Scheduled Tribes and Muslim communities who tend to drop out of school after primary education level. Being girls-only schools removes a cultural barrier and worry about safety for girls in mixed-sex situations. The schools' residential facilities allow girls from further afield (who live too far away to make the journey every day) to enrol. The schools offer a wide range of subjects – including dance, music, theatre and karate – to attract and interest their pupils. Government evaluations of the KGBVs in 12 states indicate that many out-of-school girls, particularly from Scheduled Tribes and Scheduled Castes, have been drawn into KGBVs. The most recent estimates put the number of KGBVs at 2,565, with nearly 200,000 girls enrolled across 27 states and union territories.[77]

NEPAL

Schools as Zones of Peace

UNICEF, with a coalition of partners, is working with the Government of Nepal on the Schools as Zones of Peace (SZOP) initiative. The aim is to protect the education system as a whole from the impact of conflict and to safeguard schools from the risk of closure or occupation by armed groups such as the police, the military or insurgents. Under SZOP, schools are rightly seen as neutral, peaceful zones where children can continue their education safely.



The initiative dates from 2003, when Nepal was rocked by armed conflict, and the coalition includes 29 NGOs and UN Agencies. Establishing meaningful peace zones in schools depends on community involvement and strong commitment by local people. Schools and communities signed a code of conduct, and coalition members, civil society and the media helped monitor the situation. Government endorsement of the SZOP initiative in May 2011 was an important milestone, and implementation guidelines were subsequently drawn up.

The peace zone initiative has kept schools open in 864 communities that were severely affected by political instability (even after the end of the armed conflict), directly benefiting around 300,000 children as of 2012. The nationwide recognition of SZOP has also put pressure on the various political parties and security forces to keep schools as 'zones of peace.'

In 2013, Nepal held an election for a second Constituent Assembly to finalize a new constitution. UNICEF's advocacy on the importance of minimizing the disturbance to education during elections paid off – the Election Code of Conduct included provisions that respect the neutrality of schools and protect children from being involved in election-related activities.[78]

Ideas for moving ahead

Steps to end exclusion and the learning crisis in education, and to fulfil the right to education of every child in South Asia include:

- Shifting the strategic focus in education towards equitable access: making determined attempts to bring the last 10 percent of excluded children into school, and ensuring that all children in school are learning.
- Prioritizing exclusion and the learning needs of out-of-school children: expanding alternative learning pathways; addressing the multiple barriers to schooling; and investing in excluded children and under-performing schools.
- Expanding Early Childhood Development to improve school readiness and retention in primary education.
- Increasing public investment in basic education to meet the international standards of 6 percent of GNP and 20 percent of national expenditure, and ensuring more efficient allocation of resources, particularly for the most marginalized.



Further reading

UNICEF: **Global Initiative on Out-of School Children**: www.unicef.org/education/bege_61659.html

The United Nations Educational, Scientific and Cultural Organization (UNESCO): **Education for All Global Monitoring Reports**: www.unesco.org/new/en/education/themes/leading-the-international-agenda/efareport/

UNESCO Institute for Statistics: www.uis.unesco.org

UN Girls' Education Initiative: www.ungei.org/

Learning Metrics Task Force: www.brookings.edu/about/centers/universal-education/learning-metrics-task-force-2

UNESCO and UNICEF: **Asia-Pacific End-of-Decade Notes on Education for All**: www.unescobkk.org/education/efa/end-of-decade-notes-on-education-for-all-in-asia-pacific/

Annual Status of Education Report India: www.asercentre.org/

Annual Status of Education Report Pakistan: www.aserpakistan.org/



States shall take measures to ensure that parents and children are supported in the use of basic knowledge of hygiene and environmental sanitation

Convention on the Rights of the Child, Article 24

Open defecation

Universal toilet use and hygienic behaviours

Diarrhoea, caused by poor sanitation and hygiene practices and unsafe drinking water, remains a major cause of child malnutrition, disease and death in many parts of the region.[79] Nearly half of India's underfive children are stunted (too short for their age), with poor sanitation being a major underlying cause.[80] Open defecation also puts the health and safety of women and girls at risk. While the proportion of people practising open defecation is declining, the region is not on track to meet the MDG target for sanitation.

Since 1990, the proportion of people practising open defecation in South Asia has fallen from 68 percent to 41 percent. But the number of people not using a toilet is still huge: it is estimated that there are still 681 million open defecators in the region (there were 771 million in 2000).[81] More than a third of the schools in the region do not have toilets,[82] and South Asia sustains significant economic losses due to poor sanitation.[83]

The primary challenge to reducing open defecation is that it is socially accepted behaviour in much of the region. Many consider toilets to be unclean, and some actively prefer to defecate in the open. Perhaps not surprisingly, the cleaning of toilets in public buildings – including schools and health centres – is often neglected. Compounding this cultural acceptance of open defecation is an acute shortage of capacity to implement community sanitation programmes. Although promoting sanitation and hygiene might logically fall under the remit of government frontline workers – Auxiliary Nurse-Midwifes, Accredited Social Health Activists, Anganwadi Workers, Female Community Health Workers and the like – their core work priorities mostly prevent them from taking a substantial role.

Despite these twin problems of culture and capacity, there have been some notable successes. In Bangladesh, open defecation in rural



areas fell from 23 percent in 2000 to 3 percent in 2012.[84] Nepal has succeeded in eliminating open defecation in 15 of its 75 districts and in more than 1,600 of its village development committees.[85] Governments in South Asia are committed to address sanitation, with open defecation as a priority, and national targets have been set.

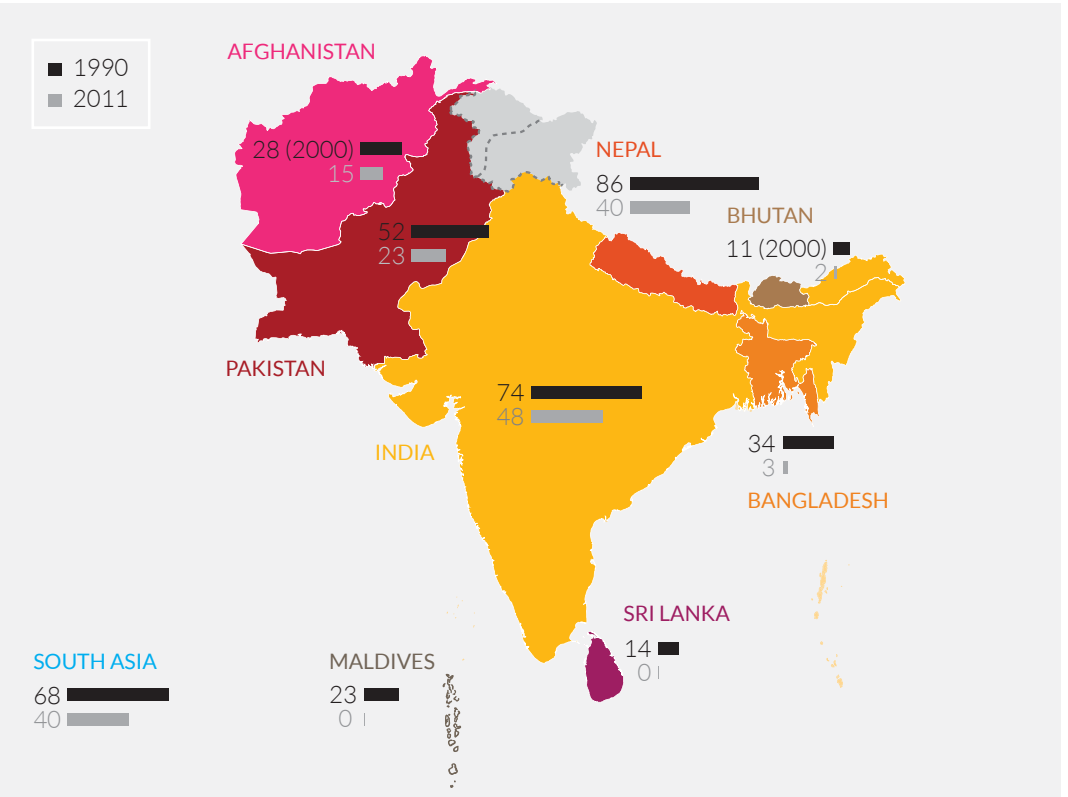
The cultural climate may be changing too – a recent survey in Bihar found that there is wide demand for toilets, even in rural areas where almost everyone practises open defecation: 84 percent of households surveyed said they would like a toilet, and 38 percent of these households actually looked into toilet options.[86] But it is interesting to note that the important connection with health has not yet been absorbed: people mentioned convenience, privacy, and the safety of women and children – rather than the prevention of diarrhoeal disease – as the main reasons for wanting a toilet.

India accounts for about 90 percent of the open defecators in the region.[87] States with the most rural open defecators are Uttar Pradesh (129 million), Bihar (80 million), Maharashtra (53 million), Madhya Pradesh (52 million), Rajasthan (45 million), West Bengal (38 million) and Odisha (33 million).[88] Afghanistan, Bangladesh, Nepal and Pakistan have much smaller numbers of people without toilets, mostly in rural areas. In India, Nepal and Pakistan, few of the poorest rural households have a toilet.[89]

There is a 44 percentage-point difference between the open defecation rates in rural and urban areas in the region as a whole, but

The proportion of people practising open defecation in South Asia has declined considerably over the last two decades

POPULATION PRACTISING OPEN DEFECATION (%), South Asia, 1990-2011



Source: UNICEF. 2013. "A snapshot of Sanitation, Hygiene and Drinking Water Safety in South Asia: 2013 update'. www.unicef.org/rosa/ROSA_Sanitation_Snapshot_2013_v21_09_13.pdf; WHO/UNICEF. 2014. "Progress on drinking water and sanitation: Joint Monitoring Programme update 2014". www.wssinfo.org/fileadmin/user_upload/resources/JMP_report_2014_webEng.pdf

Note: The dotted line between Jammu and Kashmir represents approximately the Line of Control agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

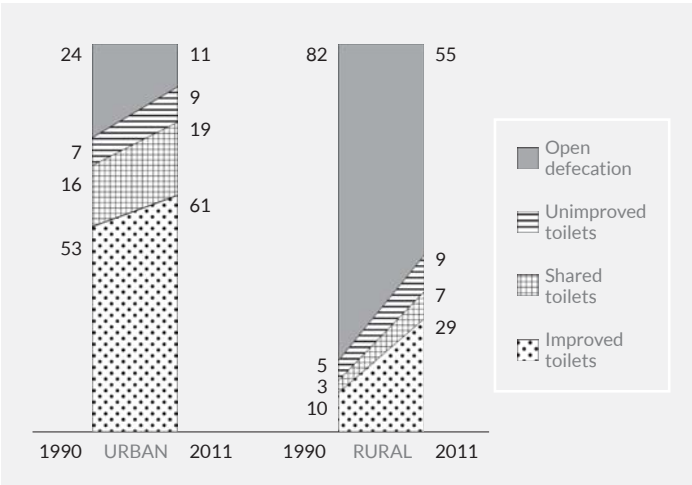
there are large in-country disparities, as shown in the graph below. The highest disparity is in India (53 percentage points), although this fell between 1990 and 2011. In 1990, one in four urban residents had no toilet, compared with eight in 10 rural residents. By 2011 there were more toilets, and the difference between urban and rural settings had narrowed slightly – only one in 10 urban residents lacked a toilet, compared with one in two rural residents.

Household wealth is also significant – the poorest households have far less access to improved sanitation than richer households in many South Asian countries. Open defecation rates too are higher for poorer households.

Economic inequalities do not necessarily improve over time. In Nepal, for example, open defecation rates have not fallen evenly across all levels of household wealth: between 2006 and 2011, the poorest households have seen the least improvement.

Sanitation coverage is much higher in urban than rural areas in South Asia

POPULATION COVERED BY IMPROVED, SHARED, AND UNIMPROVED TOILETS AND PRACTISING OPEN DEFECATION (%), IN RURAL AND URBAN AREAS, South Asia, 1990-2011

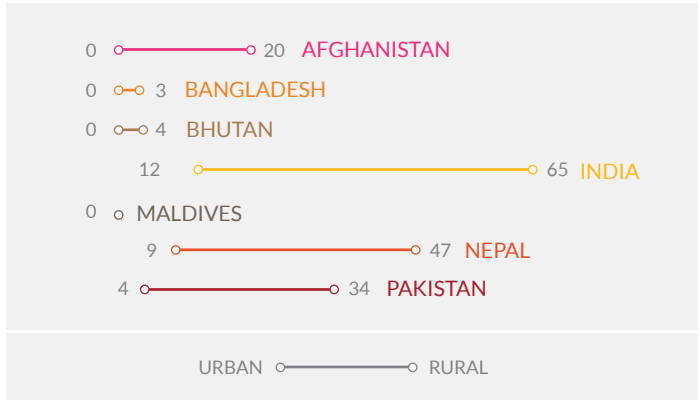


Source: UNICEF. 2013. "A snapshot of Sanitation, Hygiene and Drinking Water Safety in South Asia: 2013 update'. www.unicef.org/rosa/ROSA_Sanitation_Snapshot_2013_v21_09_13.pdf



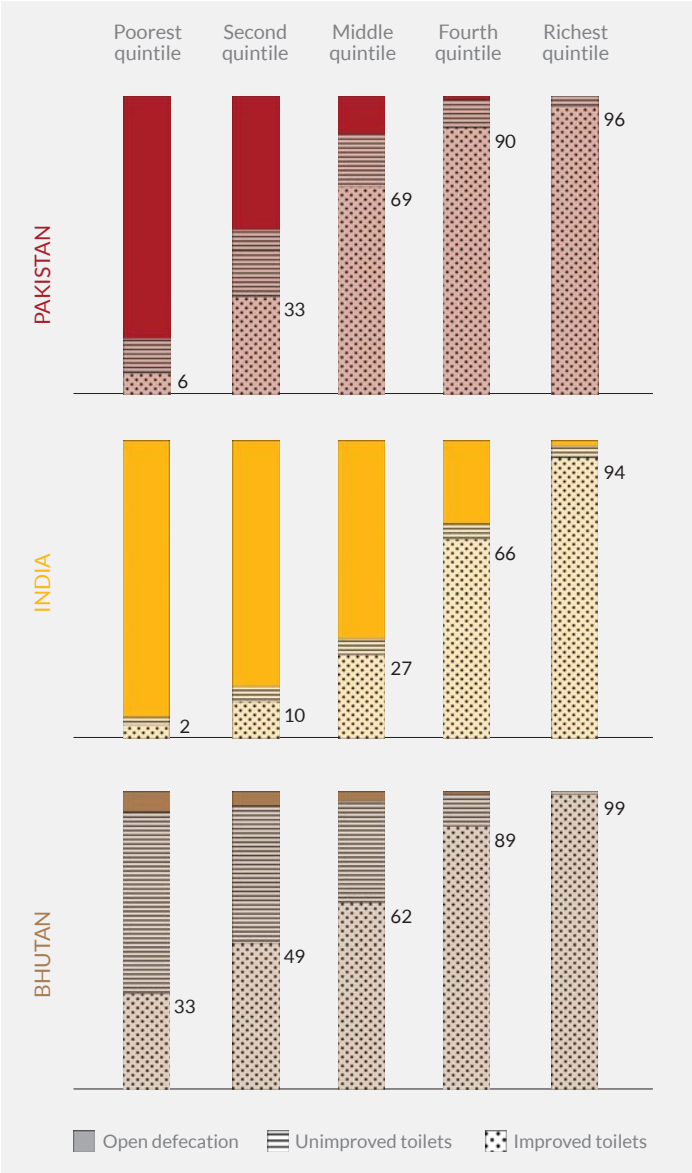
The degree of urban–rural disparity varies significantly from country to country

POPULATION PRACTISING OPEN DEFECATION (%) IN URBAN AND RURAL AREAS, South Asian countries, 2012



Source: WHO/UNICEF. 2014. "Progress on drinking water and sanitation: Joint Monitoring Programme update 2014". www.wssinfo.org/fileadmin/user_upload/resources/JMP_report_2014_webEng.pdf

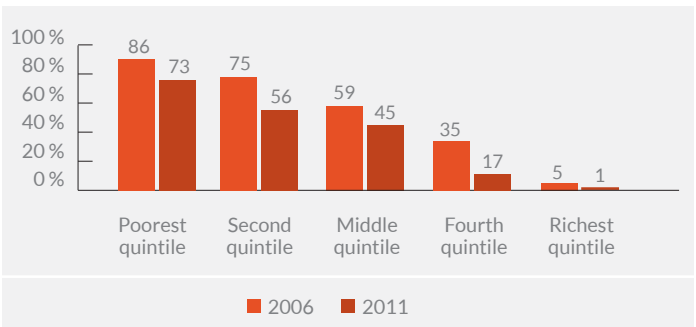
POPULATION COVERED BY IMPROVED AND UNIMPROVED SANITATION FACILITIES, AND PRACTISING OPEN DEFECATION (%), BY WEALTH QUINTILE, Pakistan, India, and Bhutan, 2005-2010



Source: Pakistan Demographic and Health Survey 2006-2007; India National Family Health Survey 2005-2006; Bhutan Multiple Indicator Cluster Survey 2010



POPULATION PRACTISING OPEN DEFECATION (%) BY WEALTH QUINTILE, Nepal, 2006-2011



Source: Nepal Demographic and Health Survey 2006 and 2011

Innovations and impact

INDIA

Nirmal Bharat Abhiyan (Clean India Campaign) and Take the Poo to the Loo campaign

The Government of India has a fully funded national flagship rural sanitation programme, Nirmal Bharat Abhiyan (Clean India Campaign). This programme, which started in 2012, is working to bring sanitation to all rural areas over the decade to 2022 and get rid of open defecation. It is hoped that this transformation of rural India will be achieved via community-led and people-centred strategies that stress the total sanitation approach. Although the programme as a whole has yet to gain momentum, some states (such as Maharashtra, inspired by the work of the social reformer Sant Gadge Maharaj) have achieved considerable progress. Sikkim and Kerala are mostly open defecation-free and Himachal Pradesh is making rapid progress through innovative community mobilization. India's new Prime Minister has publicly spoken about the importance of addressing sanitation. The private sector is also showing great corporate social responsibility towards sanitation and hygiene.

The Take the Poo to the Loo campaign, supported by UNICEF, is a digitally-led, interactive campaign to create awareness of open defecation, with a focus on young urban dwellers. The aim is to create a sense that open defecation is not acceptable, and that everyone can and should use a toilet. As of June 2014, more than 115,000 people have signed a pledge calling on the President of India to rise to the challenge of making India free of open defecation.





PAKISTAN

Pakistan Approach to Total Sanitation

The Pakistan Approach to Total Sanitation (PATS) initiative was conceived as the country recovered from the devastating floods of 2010. PATS aims to get rid of open defecation through concerted action based on creating demand for toilets through education and raising awareness. Communities and schools lead the activities, which include 'selling' the idea of sanitation and promoting hand-washing with soap – as a result, there is rising household demand for the supplies and services needed to build toilets. PATS was at first implemented by non-governmental partners with UNICEF funding, but the approach is now being adopted by some provincial governments. The approach has evolved considerably since its inception in 2010, and is now used by all sanitation-sector agencies in Pakistan. By April 2014, PATS had resulted in more than 4,200 communities with a population of more than five million becoming free of open defecation.[90]

NEPAL

A social movement for sanitation

A major diarrhoea outbreak in 2009 triggered a concerted effort – the Aligning for Action to Make Diarrhoea Epidemics History



initiative – to tackle sanitation and hygiene. Starting in early 2010, it is a coordinated programme between UNICEF, regional and district government structures, and a range of other stakeholders.

To provide a framework for collaborative efforts at all levels, government and partners have developed a comprehensive Sanitation and Hygiene Master Plan. This Cabinet-approved Plan, which is owned by seven line Ministries and the National Planning Commission, was launched by the President of Nepal in 2011. Partners agreed the programme would operate at several levels – from grassroots to regional – and would involve all the relevant sectors – health, education, water, youth groups, women's groups, political parties, media and the private sector. The movement seeks to trigger action at all levels, using a range of tools and techniques. Communication channels are many and various – face-to-face interactions, community events, religious institutions, school curriculum, mass media and advocacy. The main emphasis is on changing behaviour by using an adapted version of Community Approaches to Total Sanitation. The programme is focused on the most disadvantaged communities throughout the country.

So far, Nepal has succeeded in eliminating open defecation in 15 of its 75 districts and in more than 1,600 village development committees, as well as 18 municipalities and more than 3,300 school catchment areas.[91]

Ideas for moving ahead

To achieve sustained changes in sanitation practices, the following actions are required:

- Bringing the sanitation crisis into the open by talking freely about the problem of open defecation and human excreta.
- Using community approaches rather than simply building toilets (ending open defecation is a matter of changing behaviour and creating a new social norm that frowns on open defecation): communicating actively for behaviour change, marketing the idea of sanitation and stimulating the demand for toilets.
- Focusing on women and adolescents, and on inclusive measures to reduce disparities at all levels.
- Prioritizing sanitation and hygiene in education and health: ensuring that all schools, health centres and places of work have basic water supplies, clean toilets and facilities for hand-washing.

Further reading

World Health Organization (WHO) and UNICEF: **Joint Monitoring Programme for Water Supply and Sanitation**: wssinfo.org

Sanitation Updates: sanitationupdates.wordpress.com/

India Sanitation Portal: www.indiasanitationportal.org/

International Water and Sanitation Centre (IRC) on sanitation: www.ircwash.org/topics/sanitation

Water and Sanitation Program (WSP) on scaling up rural sanitation: www.wsp.org/global-initiatives/global-scaling-sanitation-project

WHO on water supply, sanitation and hygiene development: www.who.int/water_sanitation_health/hygiene/en/

Hygiene Central: www.hygienecentral.org.uk/

Loughborough University's Water, Engineering and Development Centre: wedc.lboro.ac.uk/knowledge/know.html

Wash-in-Schools: www.washinschoolsmapping.com

Nirmal Bharat Abhiyan (Clean India Campaign): tsc.gov.in/tsc/NBA/NBAHome.aspx

Take the Poo to the Loo campaign: www.poo2loo.com



Every child
has the right
to survival and development
to the fullest extent possible

Convention on the Rights of the Child, Article 6

Child marriage

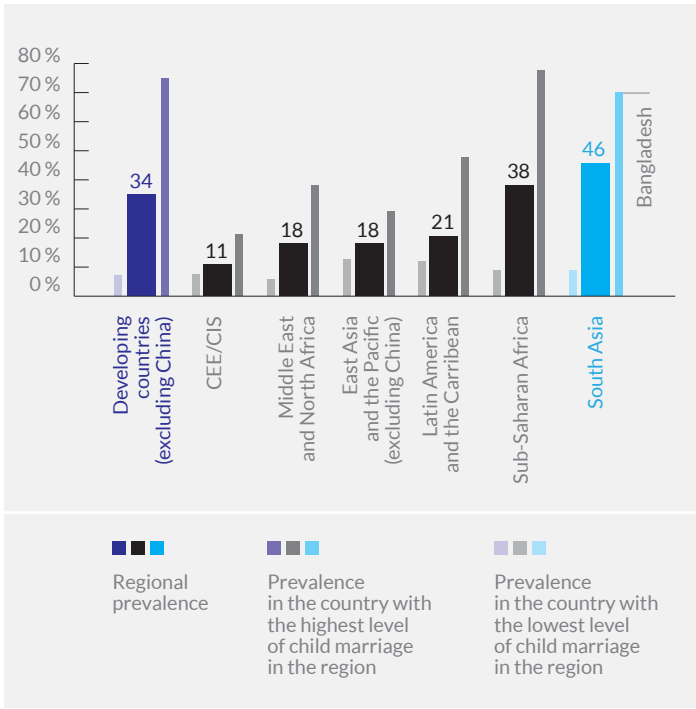
Too young to wed

Child marriage – the formal marriage or informal union involving a girl or boy under the age of 18 years – is a human-rights violation and a key area for action. Child marriage is not only a rights violation in itself, it also hinders the enjoyment – particularly for girls – of other rights such as to protection, participation, education, health and the development of their full potential. Married children not only suffer separation from family and friends, they also face decreased educational opportunities, a lack of freedom to interact with peers and a lack of livelihood opportunities. Child marriage can result in bonded labour, sexual exploitation and intimate partner violence (including sexual violence) against child brides. Because they often cannot choose to abstain from sex or insist on condom use, child brides are exposed to early pregnancy and sexually transmitted infections, including HIV. The well-being, health and development of children today will have an impact on their children and the overall social and economic health of South Asia tomorrow.

Almost half of all girls in South Asia (46 percent)[92] marry before the age of 18. One in five girls (18 percent) are married before the age of 15.[93] These are the highest rates in the world. Moreover, of the global population of women aged 20-24 who married before age 18, more than one third live in South Asia: 24 million out of 68 million in 2010.[94] The highest rate of child marriage is in Bangladesh (where two out of every three girls marry before age 18), followed by India, Nepal and Afghanistan. Four percent of adolescent boys and 29 percent of adolescent girls (aged 15-19) are currently married or in union in South Asia.[95] These figures confirm that child marriage is rooted in gender norms and in expectations about the value and roles of girls.

Where it is prevalent, child marriage is rooted in social norms. Parents marry their daughters off at an early age because they see

WOMEN AGED 20–24 WHO WERE FIRST MARRIED OR IN UNION BEFORE THE AGE OF 18 (%), different regions, 2007-2008



Source: UNICEF. 2010. "Progress for Children: Achieving the MDGs with Equity (No. 9)". www.unicef.org/publications/files/Progress_for_Children-No.9_EN_081710.pdf

Note: Based on a subset of 97 countries covering 61 percent of the world population. CEE/CIS: Central and Eastern Europe and the Commonwealth of Independent States.

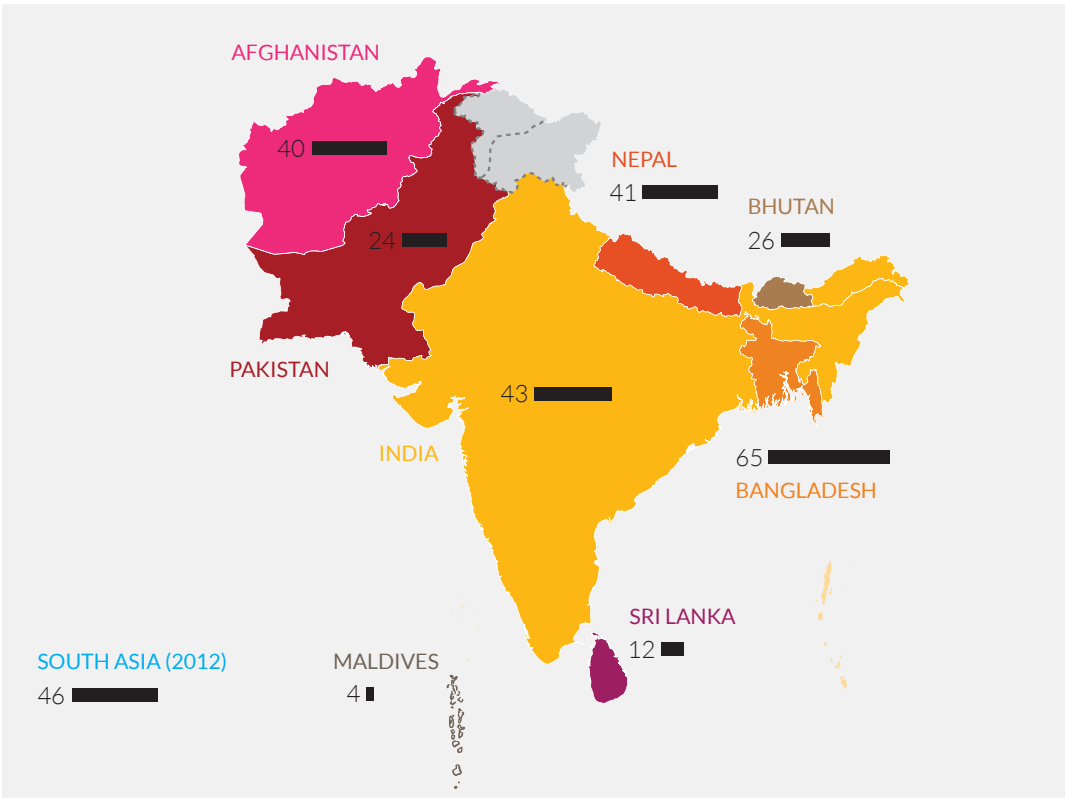


it as the 'done thing', and because they fear the social sanctions and moral judgments they would face if they refused to follow this practice.

Girls from poor families are more likely to get married before the age of 18 than their peers in richer families. In countries for which information is available, the largest difference between girls from the poorest and richest families is found in India (75 percent versus 16 percent).[96] The disparity is also considerable in Bangladesh (80 percent versus 53 percent) and Pakistan (46 percent versus 18 percent).[97] According to United Nations Population Fund (UNFPA) figures, South Asia's overall regional disparity by wealth is greater than any other region: 18 percent of women aged 20-24 from the

Almost half of all girls in South Asia marry before they are 18

WOMEN AGED 20-24 WHO WERE FIRST MARRIED OR IN UNION BY THE AGE OF 18 (%), South Asia, 2005-2013



Source: UNICEF. 2014. "The State of the World's Children 2014 in Numbers. Every Child Counts: Revealing disparities, advancing children's rights". www.unicef.org/sowc2014/numbers/, District Level Household and Facility Survey 2007-08, India

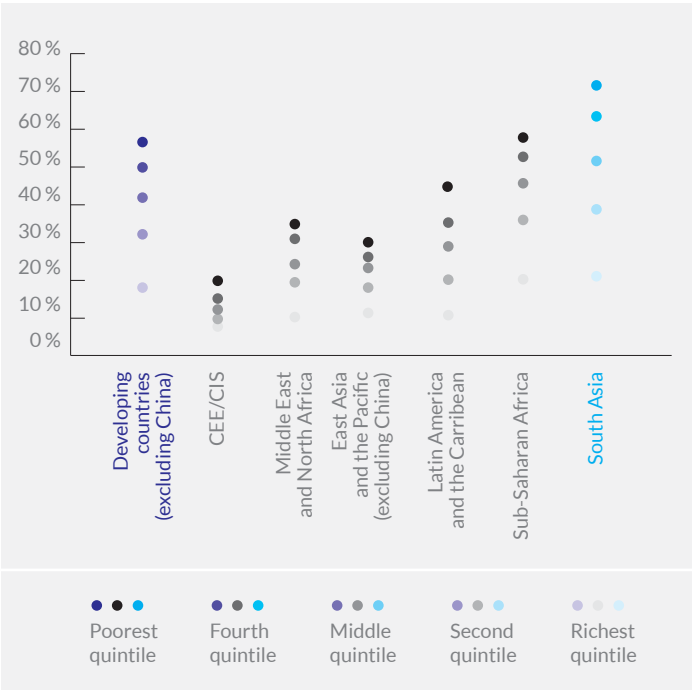
Note: Data for 1989 is not available for most countries in South Asia.

The dotted line between Jammu and Kashmir represents approximately the Line of Control agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

richest families are married or in union by 18, whereas the equivalent figure for the poorest families is 72 percent.[98]

Girls in rural areas are also more likely than girls in towns to get married while still children themselves. In South Asia, 54 percent of women aged 20-24 living in rural areas were married before 18, compared to 29 percent in urban areas.[99] India shows the biggest gap here – with 48 percent in rural areas compared to 29 percent in towns.[100] The rural/urban disparity is somewhat lower in other countries: 70 percent versus 53 percent in Bangladesh,[101] 33 percent versus 26 percent in Bhutan,[102] 47 percent versus 43 percent in Afghanistan[103] and 29 percent versus 16 percent in Pakistan.[104]

WOMEN AGED 20–24 WHO WERE FIRST MARRIED OR IN UNION BEFORE THE AGE OF 18 (%) BY WEALTH QUINTILE, different regions, 2000-2008



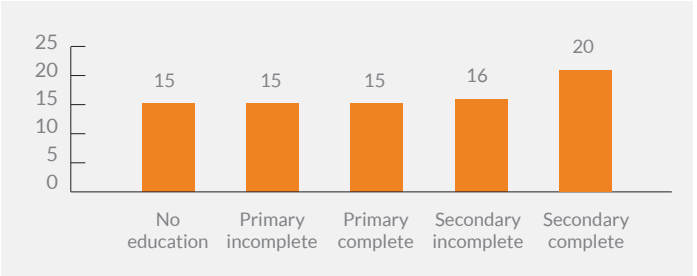
Source: UNICEF. 2010. "Progress for Children: Achieving the MDGs with Equity (No. 9)". www.unicef.org/publications/files/Progress_for_Children-No.9_EN_081710.pdf

Note: Based on a subset of 80 countries covering 52 percent of the world population. CEE/CIS: Central and Eastern Europe and the Commonwealth of Independent States.





MEDIAN AGE (YEARS) AT FIRST MARRIAGE AMONG WOMEN AGED 20-49, Bangladesh, 2011



Source: Bangladesh Demographic and Health Survey 2011

Education plays a critical role in addressing child marriage. In India, girls with no education are 5.5 times more likely to marry or enter into union as those with at least 10 years of education (77 percent of women aged 20-24 who have no education are married by age 18 compared to only 14 percent of those who completed at least 10 years of education).[105] And in Bangladesh, women aged 20-49 with secondary or higher education marry about five years later than their peers with no education.[106] They also have an average of 2.5 fewer children.

Given these statistics, it may come as a surprise to learn that most countries in South Asia have a legal minimum age for marriage. This is generally 18 years except in Afghanistan and Pakistan, where the gender norms endorsing earlier girl marriage are reflected in different



minimum ages – 16 for girls and 18 for boys. Legislation alone is clearly insufficient to tackle child marriage – even where there is a legal minimum age, many families, including children themselves, are unaware of the fact, and enforcement of the legislation is weak.

The figures clearly show correlation between higher rates of child marriage and risk factors such as poverty, low levels of education, and place of residence (rural/urban or geographical area). Unequal gender norms value boys and men higher than girls and women, so families and communities invest less in girls' education and development. Poverty is a major factor – girls are seen as an economic burden, so poor families prefer to invest their meagre resources in the education of their sons; poor parents may also believe that marriage will secure a good future for their daughter. The customs of bride price and dowry may also provide financial incentives for child marriage.

Although the proportion of child brides, particularly of those under the age of 15, has decreased over the past 30 years, child marriage remains common and socially accepted throughout South Asia. Child marriage rates remain unacceptably high despite many joint efforts by governments, non-governmental organizations (NGOs) and UN agencies. If nothing changes, 130 million South Asian girls will marry or enter a union between 2010 and 2030. This is close to 18,000 girls per day, according to UNFPA.[107]

Innovations and impact

INDIA

Bringing education and empowerment to girls in remote communities

The Deepshikha (Light a Lamp) programme is educating and empowering adolescent girls in four remote districts of Maharashtra State, to give them a greater say in decisions that affect them. Deepshikha was launched by UNICEF in 2008 in partnership with the Government of Maharashtra and local NGOs, and with sponsorship by Barclays Bank. More than 2,850 Adolescent Girls Groups have been set up so far, reaching more than 70,000 girls.

The programme is having clear results – many child marriages have been prevented, girls who had dropped out of formal education have returned to school, several young women have been elected into local self-governance bodies, and some have even taken on leadership positions within village decision-making structures (known as gram panchayats). The Deepshikha life skills component has been incorporated into several national government schemes, including the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls – SABLA, the National Programme for Education of Girls at Elementary Level (NPEGEL) and Kasturba Gandhi Balika Vidyalaya (KGBV). The Government of Maharashtra has adopted the model to replicate in 125 most backward community development blocks in 25 districts through the Maharashtra Human Development Commissionerate, which is reaching more than 300,000 girls.





The Deepshikha programme has empowered thousands of adolescent girls, giving them greater confidence, higher aspirations and the knowledge and skills to challenge traditional discriminatory beliefs and practices towards women.[108]

NEPAL

Addressing child marriage through child clubs

Concerted efforts have reduced the prevalence of child marriage in Kalikot, a remote mountain district in mid-Western Nepal. Awareness-raising activities by a range of clubs for women and children, and frequent radio and cultural programmes organized by NGOs have together helped raise the profile of child marriage. Child clubs have played a critical role – the Karnali Integrated Rural Development and Research Centre (KIRDARC) taught members about human rights and how child marriage violates child rights. Children's clubs then took action, performing street dramas with messages against child marriage and intervening directly with parents who planned to marry off their children before the age of 18.[109]

Ideas for moving ahead

Fighting child marriage calls for:

- Enacting legislation that increases the minimum age of marriage for girls (and boys) to 18 years, complemented by awareness-raising and enforcement of the law, and strengthening birth and marriage registration systems.
- Enhancing equal access to good quality primary and secondary education, to eliminate gender gaps in schooling.
- Providing economic support and incentives for girls so that their families can counteract the financial motives for child marriage.
- Mobilizing, educating and raising awareness among parents, community members, village elders and religious leaders to address discriminatory gender norms and create new positive norms and opportunities for girls.
- Empowering adolescent girls by providing information, strengthening skills and establishing support networks to enable them to protect their rights, build their futures and actively participate in the development of their communities.[110]



Further reading

Asian Forum of Parliamentarians on Population and Development: "**Review of national legislations and policies on child marriage in South Asia**": www.afppd.org/files/5214/0047/3090/Review_of_National_Legislations_and_Policies_on_Child_Marriage_in_South_Asia.pdf

Centre for Reproductive Rights: "**Child Marriage in South Asia: Stop the Impunity**": reproductiverights.org/sites/crr.civicactions.net/files/documents/ChildMarriage_BriefingPaper_Web.pdf

Human Rights Watch: "**Brochure on ending child marriage and domestic violence in Afghanistan**": www.hrw.org/sites/default/files/related_material/Afghanistan_brochure_0913_09032013.pdf

International Centre for Research on Women (ICRW): "**Impact on Marriage: Programme Assessment of Conditional Cash Transfers**": www.icrw.org/files/publications/IMPACCT_Hires_FINAL_3_20.pdf

Plan International and ICRW: "**Asia Child Marriage Initiative: Summary of Research in Bangladesh, India and Nepal**": plan-international.org/files/Asia/publications/asia-child-marriage-initiative-summary-of-research-in-bangladesh-india-and-nepal.pdf

UNFPA, ICRW, Australian Agency for International Development (AusAID) and Asian Forum of Parliamentarians on Population and Development (AFPPD): "**Child Marriage in Southern Asia. Policy Options for Action**": www.icrw.org/publications/child-marriage-southern-asia

UNFPA: "**Marrying too young: End child marriage**": www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf

UNICEF: "**Emerging concerns and case studies on child marriage in Sri Lanka**": www.unicef.org/srilanka/Final_Uploaded_report_compress.pdf



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[3] Calculation based on data in: World Bank. n.d. World Development Indicators: Internet users. http://data.worldbank.org/indicator/IT.NET.USER.P2 [accessed 4 July 2014]. Excludes Bhutan and the Maldives

[4] World Bank. n.d. World Development Indicators: Access to electricity. http://data.worldbank.org/indicator/EG.ELC.ACCS.ZS [accessed 4 July 2014]

[5] UN ESCAP/ADB/UNDP. 2013. "Asia-Pacific Aspirations: Perspectives for a Post-2015 Development Agenda. Asia-Pacific Regional MDGs Report 2012/13". http://asia-pacific.undp.org/content/dam/rbap/docs/Research%20&%20Publications/mdg/RBAP-RMDG-Report-2012-2013.pdf

[6] UN News Centre. 2010. "Mobile telephones more common than toilets in India, UN report finds". www.un.org/apps/news/story.asp?NewsID=34369#.U5V5Q3KSweE

[7] World Bank. 2012. "More and Better Jobs in South Asia" http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/223546-1296680097256/7707437-1316565221185/Jobsoverview.pdf

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Printed in September 2014